the Canadian Nurse

VOLUME 59 • NUMBER 5

MONTREAL

MAY 1963

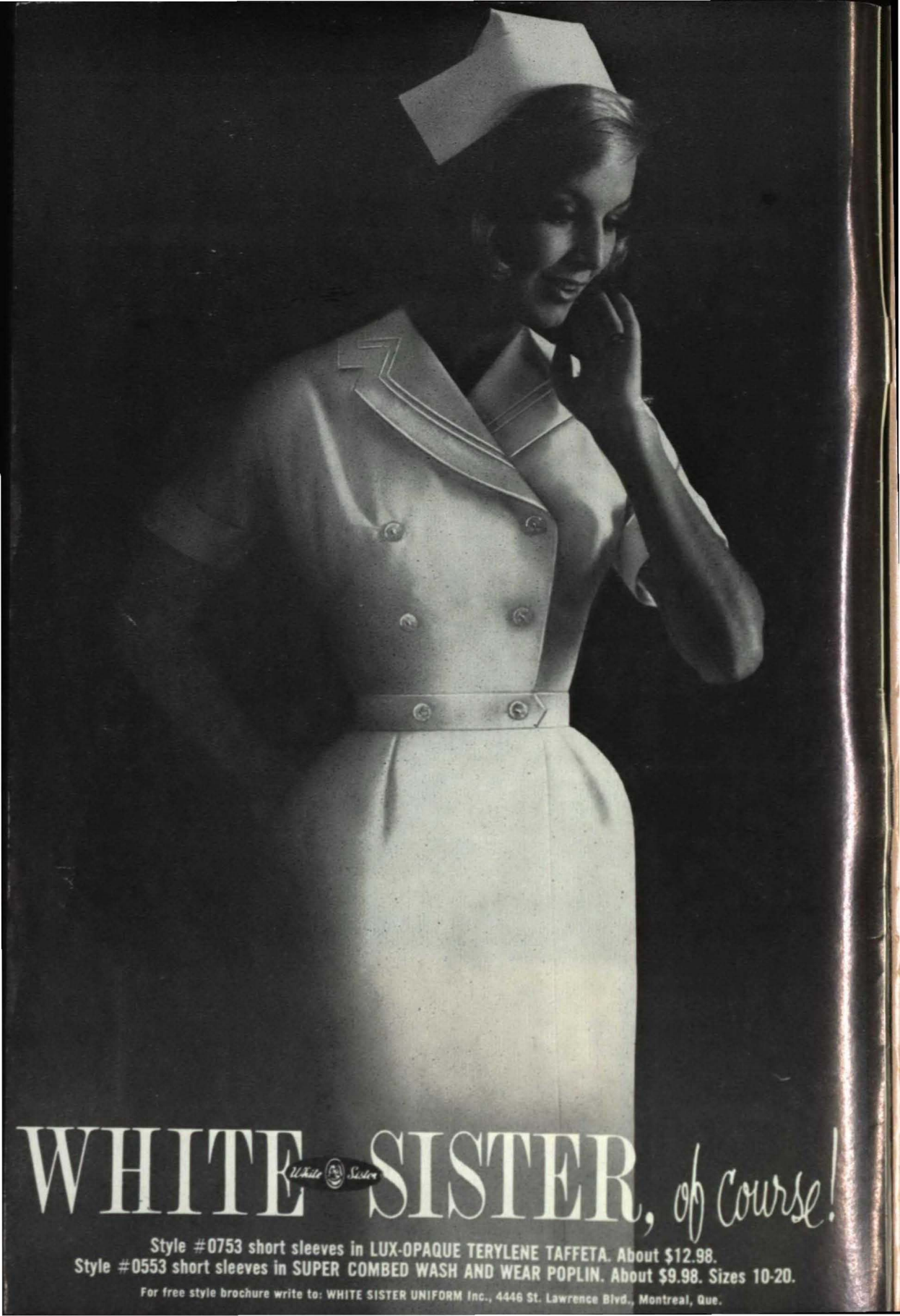
THE EMOTIONAL ASPECTS OF ILLNESS

THE ROLE OF THE TEACHER-COUNSELOR

NURSING EDUCATION — THE CHIEF TOPIC IN OTTAWA

OWNED AND PUBLISHED BY

THE CANADIAN NURSES' ASSOCIATION



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Between Ourselves

Periodically, nurses have been heard to ask: "What goes on at all of these meetings that our people go to in Ottawa?" Many of the answers will be found in various places in this issue. First, our national president, E. A. ELECTA MACLENNAN notes, in her editorial, the on-going emphasis during this biennium on the key themes that both nursing education and nursing service predicated at last year's convention. JUNE FERGUSON'S summary of the Executive Committee's discussion of the many reports that were presented, illustrates the progress that is being made in expanding the themes. In tune with the national program, the condensation of the reports presented by the provincial executive secretaries demonstrates how all of these developments eventually reach right back to each member of the Canadian Nurses' Association.

* * *

An opportunity to share the knowledge and skills that they have acquired in the course of their nursing education and experience awaits any nurse who has the necessary time and interest. Where? In teaching classes in home nursing in her own community.

Both St. John Ambulance Association and the Canadian Red Cross Society provide excellent courses in home nursing. There are scores of women and perhaps also a scattering of men who would like to have an opportunity to acquire some understanding of the principles and techniques of caring properly for one who is sick in the home. Both organizations feel that the person most capable of providing this instruction is a fully qualified nurse. With thousands of nurses in Canada, one could imagine that every community might be swarming with organized classes.

Somehow, it does not work out that way and either the classes have to be held in abeyance or a few volunteer nurse teachers have to carry too heavy a load. Within a period of three weeks last winter we received appeals from four different parts of the country — "Can you suggest any way we could get nurses to help us with our home nursing classes?" Mrs. DOROTHY WARNER'S brief exposition of the need was our suggested method of calling this matter to your attention. How about it? Will you volunteer as a teacher?

* * *

Though graduation exercises may be arranged for any time in the year, the month of May continues to be the traditional choice of a majority of the schools of nursing across Canada. In the days of yore, the astrologists or the soothsayers were always consulted before an event, so important and well attended, was scheduled. Were the planets in the most auspicious position? Which star was in the ascendancy? Today, the more probable questions are: How many invitations can we give each member of the class? If all of the guests come, will we have space for them? Should we rent a larger hall for the occasion because our graduating class is twice the size it used to be?

For the school of nursing staff, there are a myriad of last minute problems. For the soon-to-be graduates, there is plenty of excitement — new clothes, parties, gifts, thousands of good wishes. We at the *Journal* add our congratulations and sincere hopes for your happiness and success in nursing. We'll be seeing you soon — on our mailing lists!

* * *

Next month, the convention of the International Hospital Administrators Association is being held in Paris. Many Canadian nurses are planning to fly across the Atlantic on the chartered flight that has been arranged. We are proud to learn that the chairman of the Journal Board, Miss ALICE GIRARD, is presenting one of the papers. We have asked one of the nurse hospital administrators who is attending the convention to summarize the proceedings for publication in a future issue.

The sixth annual meeting of the National League for Nursing wil be held May 13-17 in Atlantic City, N.J. Topics will range from world events to community activities — and how these affect and are affected by nursing. — N.L.N.

THE CANADIAN NURSE

VOLUME 59 NUMBER 5

MAY 1963

429 THINK ON THESE THINGS ..... *E. A. E. MacLennan*

431 THE EMOTIONAL ASPECTS OF ILLNESS ..... *J. Mossing*
Miss Mossing, formerly Psychiatric Nursing Instructor, Moose Jaw Union Hospital, Moose Jaw, Sask., is presently In-Service Education Supervisor, Victoria Union Hospital, Prince Albert, Sask.

435 THE ROLE OF THE TEACHER-COUNSELOR ..... *M. M. Conroy*
Mrs. Conroy is Clinical Coordinator in the School of Nursing at St. Joseph's Hospital, Sudbury, Ont.

438 STAFF EDUCATION IN THE OPERATING ROOM ..... *L. Perrin*
Miss Perrin was a postgraduate at Winnipeg General Hospital when she wrote this study.

440 THE QUEBEC CURRICULUM FOR ENGLISH SCHOOLS OF NURSING ..... *A. A. Christie*
Miss Christie, formerly Director of Nursing Education at The Montreal General Hospital School of Nursing, is now Educational Consultant to the New Brunswick Association of Registered Nurses.

443 HYPERTENSIVE HEART DISEASE ..... *Sr. M. Frances*
Sister Marguerite Frances is a graduate of Halifax Infirmary, N.S.

445 OUTPOST NURSING STATION ..... *W. J. Wood and A. M. Swail*
Dr. Wood was Regional Superintendent (recently resigned) and Miss Swail is Regional Nursing Officer of the Central Region, INHS.

448 PATTERN OF DECISION-MAKING IN STAFF ROUNDS ..... *P. C. Pike*
Miss Pike is in charge of the Nursing Research Department of the Allan Memorial Institute, Royal Victoria Hospital, Montreal.

452 PROBLEMS! DILEMMAS! QUESTIONS! ..... *T. Pelley*
Miss Pelley is Nursing Secretary, C.N.A.

459 NURSING EDUCATION — THE CHIEF TOPIC IN OTTAWA ..... *J. Ferguson*
Miss Ferguson is Public Relations Secretary with the CNA.

461 WANTED: MANY TEACHERS ..... *D. Warner*
Mrs. Warner is Chief Nursing Officer with St. John Ambulance at its National Headquarters in Ottawa.

464 DISASTER NURSING ..... *J. Shave*
Miss Shave is a Registered Nurse in Newfoundland.

466 PROFESSIONAL APPEARANCE ..... *G. Saunders*
Miss Saunders had been a student at the Kingston General Hospital School of Nursing for four months when she was asked to present a Morning Circle on this topic.

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of The Canadian Nurse *nor of the Canadian Nurses' Association.*

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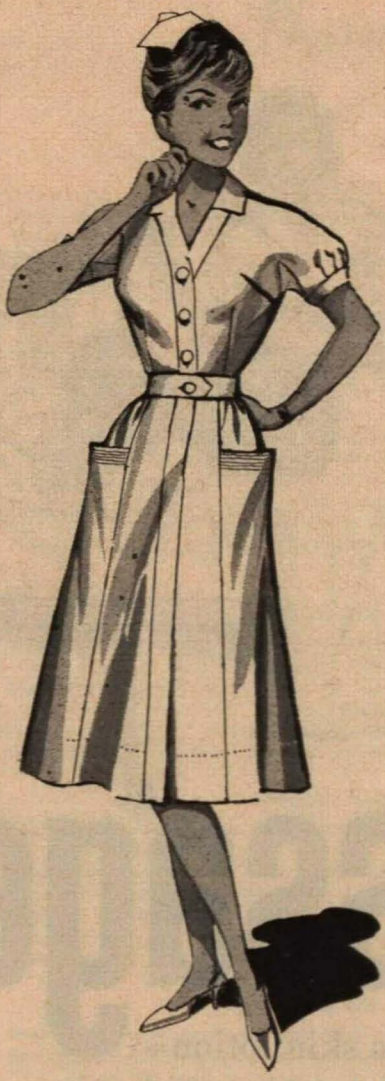

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Random Comments

Dear Editor:

We are trying to complete our collection of the *Journal* from 1956 to date. If any reader of this periodical would like to contribute her back issues for the education of future nurses, our school would be most appreciative.

William J. Spangler, Librarian,
Methodist Hospital,
2301 South Broad St.,
Philadelphia 48, Pa.

¶ *If nurses in Canada wish to send their back issues to the Journal office, we will forward them for you.* Ed.

Dear Editor:

Your article "Personal Financial Planning" (Dec. 1962) by R. F. Smith is a gem. It is one of the best articles I have read.

HUGH S. ROSE, Regional Manager, King Merritt & Co. Ltd., Sherbrooke, Que.

Dear Editor:

The Winnipeg Children's Hospital Nurses' Alumnae would like to hear from all past graduates of the school who plan to attend the Hospital's 50th reunion. Registration will begin on August 18, 1963.

The reunion will extend to August 24, and will include teas, tours, dinner and individual get-togethers among its activities.

Please address all correspondence to:

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303 Furby St.,
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Dear Editor:

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EILEEN MINTY, Ontario

Dear Editor:

I would like to make further comment regarding the placement of the author's biographical data.

. . . Several professional publications, including *The Canadian Medical Association Journal* and *The Canadian Journal of Sur-*

gery, include the author's biographical data on the first page of the article concerned.

I do not suggest that we should blindly follow any or all publications, but this must certainly indicate that a large percentage of professional people find it convenient to have the author's biographical data somewhere on the first page of the article. Sometimes a step backward can indeed be a step forward, if we are not too proud to reverse a wrong decision.

(Mrs.) GLORIA KAY, Ontario

★ *In response to several requests, we will return the information about the author to the page on which the article is published.*

Ed.

Cardiac arrest often occurs when oxygen levels in the blood are extremely low — a condition known as hypoxia. Current studies indicate that the heart stoppage results primarily from neural stimuli originating in the peripheral nerve receptors rather than from direct effects of oxygen deficit on the heart.

Investigators used two heart-lung machines, so that the coronary circulation and the systemic circulation could be perfused independently. When the heart was perfused with blood low in oxygen, but the systemic circulation was perfused with normal fully oxygenated blood, no significant change in heart rate or rhythm was noted. However, when hypoxia was produced in the systemic circulation, heartbeat slowed abnormally in all animals and ceased altogether in two of them, even though their hearts were being perfused with fully oxygenated blood.

Sudden systemic hypoxia produced more severe reactions than gradual hypoxia; the most severe reactions occurred when both the systemic circulation and the cardiac circulation were perfused with blood low in oxygen. When the vagal nerves leading to the heart were severed, the effects of systemic hypoxia were abolished.

The investigators concluded that decreased levels of oxygen in the systemic circulation somehow stimulate neural receptors which can slow and even stop the heart. This can happen when the heart itself is receiving adequate oxygen from its own blood supply.

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Simple Courtesy and the Hard of Hearing

One hardship suffered by persons with a hearing loss is the isolation, real and fancied, that their handicap imposes upon them. This is increased by the embarrassment people with normal hearing sometimes show in their presence. To help both groups, the American Hearing Society and other organizations devoted to aiding the hearing-handicapped offer these hints:

1. When you meet a person who seems inattentive or slow to understand you, consider the possibility that his hearing, rather than his manners or intellect, may be at fault. Some hard-of-hearing persons refuse to wear a hearing aid. Others wear aids so inconspicuous or cleverly camouflaged that you may not spot them at first glance.

2. Remember that the hard of hearing may depend to a considerable extent on reading your lips to understand what you're saying. They do this even though they may be wearing a hearing aid, for no hearing aid can completely restore hearing. You can help them by trying always to speak to them in a good light, and by facing them and the light as you speak.

3. When you're in a group that includes a hard-of-hearing person, try to carry on your conversation with others in such a way that he can watch your lips. Never take advantage of his handicap by carrying on a private conversation in his presence in low tones he cannot hear.

4. Speak distinctly but naturally. Shouting doesn't clarify speech sounds, and mouthing or exaggerating your words, or speaking at a snail's pace make you harder to understand. On the other hand, try not to speak too rapidly.

5. Don't start to speak to a hard-of-hearing person abruptly. Attract his attention by first facing him and looking straight into his eyes. If necessary, touch his hand or shoulder lightly. Help him grasp what you're talking about right away by starting with a key word or phrase, e.g., "Let's plan our weekend now," "Speaking of teenagers..." If he doesn't understand you, don't repeat the same words. Substitute synonyms: "It's time to make plans for Saturday," etc.

6. If the person you are speaking to has one "good" ear, always stand or sit on that side of him when you address him. And don't be afraid to ask a person with an obvious hearing loss whether he has a good ear and, if so, which one it is. He'll be grate-

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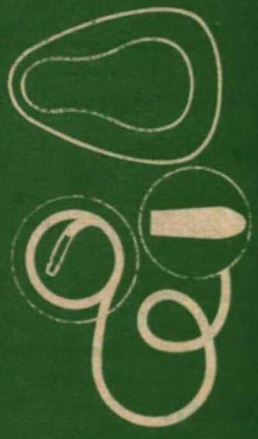

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By JOSEPHINE A. DOLAN, R.N., M.S., Professor of Nursing, University of Connecticut. About 432 pages, 5-5/8" x 9-3/4", with 293 illustrations. About $7.00.
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By GLADYS SELLEW, B.S., R.N., Ph.D., Formerly Professor of Nursing of Children, University of Maryland School of Nursing. 450 pages, 5-3/4" x 8", illustrated. $5.75. *Fifth Edition—Published May, 1962*

Stanley-Brown – Pediatric Surgery for Nurses

The steps in the surgical treatment of pediatric conditions as related to nursing care are fully described here. Fundamentals of surgical correction as well as both physical and psychological aspects of aftercare are emphasized. Photographs and line drawings provide a valuable insight into surgical procedures the nurse should understand more fully. The book contains clear and concise coverage of such topics as: preparation for ambulation — intestinal obstruction in newborn — importance of urinalysis in acute appendicitis — nursing problems following palatoplasty.

By EDWARD G. STANLEY-BROWN, M.D., Assistant Attending Surgeon, St. Luke's Hospital, New York City; Associate in Surgery, Columbia University. 172 pages, 5-3/4" x 8", illustrated. $5.00.
Published March, 1961

Cady – Nursing In Tuberculosis

This book fully describes today's procedures of complete nursing care for the tubercular patient in the home or hospital. Clear discussions of the nurse's role in meeting the patient's physical and psychological needs are made even more understandable through the use of excellent illustrations. Charts on anti-tuberculosis drugs, dosage and reactions are helpfully included.

By LOUISE LINCOLN CADY, R.N., B.S., M.A., Mental Health Nurse Consultant, Division of Mental Hygiene, Alabama State Department of Health. 489 pages, 5" x 8", with illustrations. $6.50.
Second Edition—Published April, 1961

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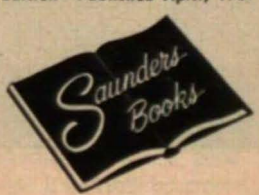

ful that you care enough to find out.

7. Facial expressions are important clues to meaning. Remember that an affectionate or amused tone of voice may be lost in a hard-of-hearing person.

8. In conversation with a person who is especially hard of hearing, do not be afraid occasionally to jot down key words on paper. If he is really having difficulty in understanding you, he'll be grateful for the courtesy.

9. Many hard-of-hearing persons — especially teen-agers, who hate to be "different" — are unduly sensitive about their handicap, and will pretend to understand you even when they don't. When you detect this situation, tactfully repeat your meaning *in different words* until it gets across.

10. When you entertain friends with a hearing loss, put away your candles. Electric light will give them a better chance to join the conversation, because they can then see your lips as you talk. Similarly, in choosing a restaurant or night club, remember that dim lighting may make lip reading difficult.

11. Don't feel you have to exclude hard-of-hearing friends from all forms of entertainment involving speech or music. True, concerts and operas may present problems, but movies, plays, ballets, dances are often just as enjoyable to people with a hearing loss as to those with normal hearing. (Even profoundly deaf persons can usually feel rhythm, and many are good and eager dancers). For children, magic shows, pantomimes, and the circus are good choices.

12. When sending a telegram to someone who does not hear well, instruct the telegraph company to deliver your message, not telephone it.

13. The speech of a person who has been hard of hearing for years may be difficult to understand, since natural pitch and inflection are the result of imitating the speech of others. To catch such a person's meaning more easily, watch his face while he talks.

14. Don't say such things as "Why don't you get a hearing aid?" or "Why don't you see a specialist?" to a person who is hard of hearing. Chances are he's already explored these possibilities, and there's no need to emphasize his handicap.

15. Use common sense and tact in determining which of these suggestions apply to the particular hard-of-hearing person you meet. Some persons with only a slight loss might feel embarrassed by any special attention you pay them. Others, whose loss is greater, will be profoundly grateful for it.

— *The Hearing Eye*, Vol. 30, No. 3, Sept. 1962.

Reprint Courtesy *Good Housekeeping* — Nov. 1957.

* * *

The University of Edinburgh has concluded an agreement with the World Health Organization, whereby an International School of Advanced Nursing Studies will be developed at the University's Nursing Studies Unit. The new school will be the first of its kind in the world. It will train selected professionally qualified nurses from the United Kingdom, Europe and other countries for appointment to senior posts throughout the world.

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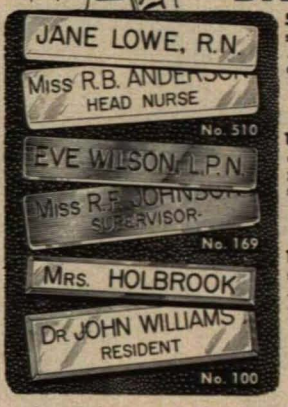

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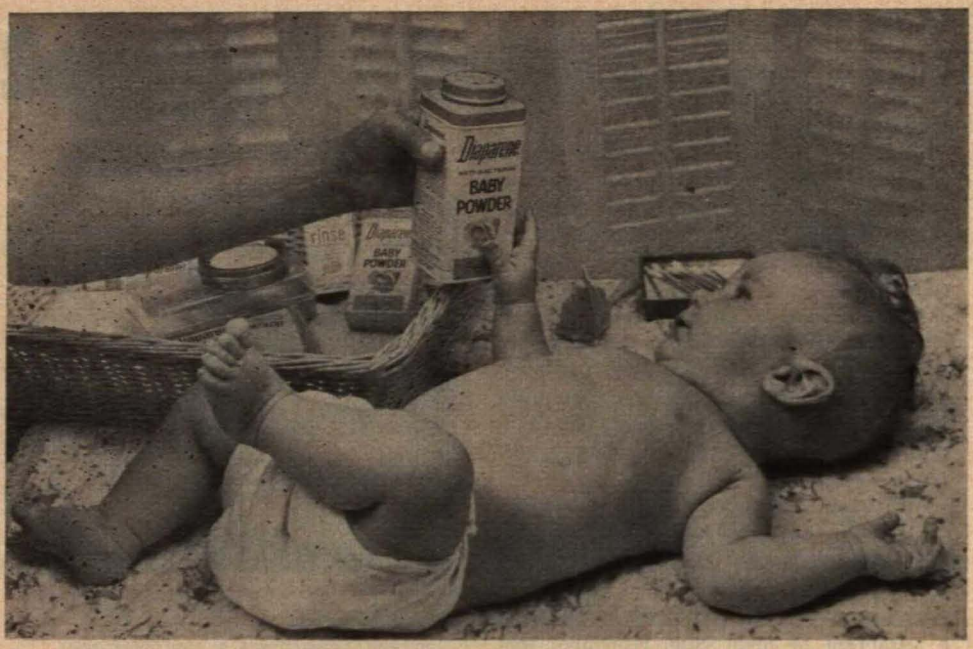

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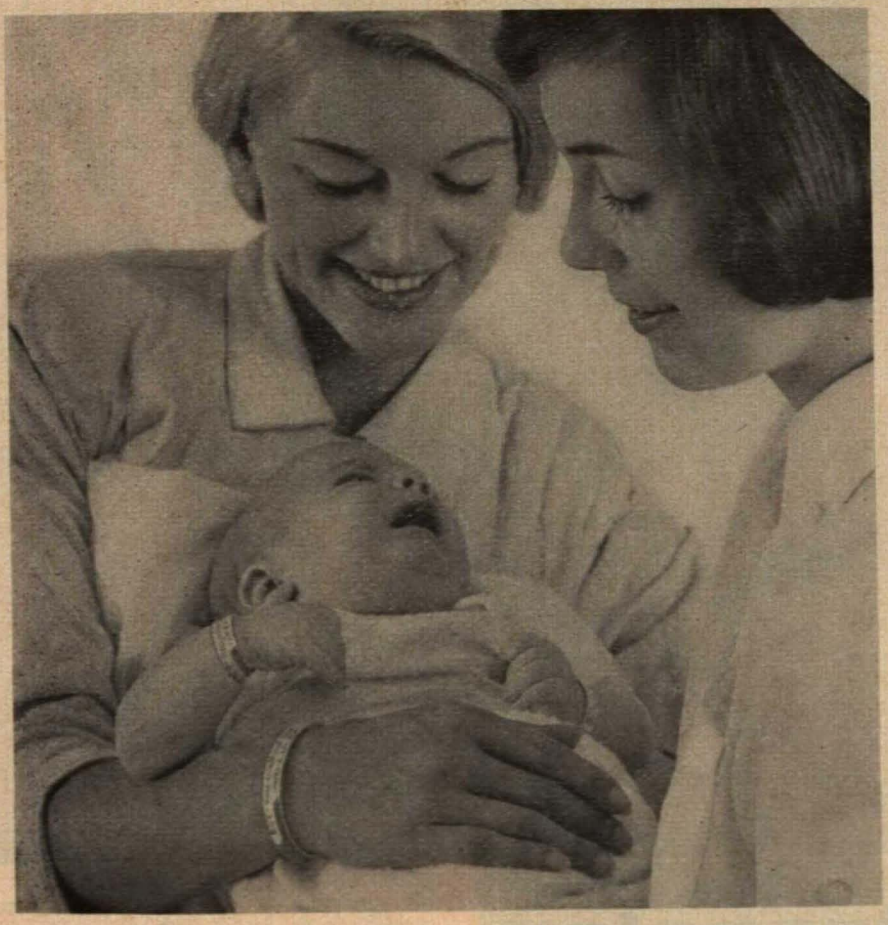

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PUBLISHED IN ENGLISH AND FRENCH
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VOLUME 59 MONTREAL, MAY 1963 NUMBER 5

Think on these Things

This is perhaps the most challenging period in the history of nursing. So often have we heard this idea expressed that it has become a well-worn, in fact, a rather weary cliché. Nevertheless, each period is entitled to its particular or peculiar "challenge." What do we consider to be the peculiar challenge of our time?

A second reading of the reports of the National Committees of our Association presented at the 1962 biennial meeting will reveal some of these "challenges." Particularly in the areas of nursing education and nursing service we can find much food for sober reflection.

Solving the complex and baffling problems of supply and demand, of quality and quantity of the nursing services requires the best brain power in our profession. How to improve the quality of these services and at the same time better prepare nurses in

(Wright, Halifax)

ELECTA MACLELLAN

ever-increasing numbers is one of the difficult tasks before us. Clear thinking and purposeful leadership are needed if the nursing profession is to continue to make a significant contribution to the health needs of society.

Midway as we are in this biennium, it is well for us to stop and take stock of our progress. In the last biennial report of the Committee on Nursing Education we are reminded "that our reason for being is to serve people, sick or well, within our competence."[1] To justify our existence we must "see that our competence is continuously evaluated and adjusted to cope with change."

And again, in the last biennial report of the Committee on Nursing Service, we are reminded that many of the recommendations made by the nursing associations to the Royal Commission on Health Services "lay a specific burden upon all nurses, but more particularly upon those nurses who are in positions to influence, through their administrative practices, the improvement of patient care."[2]

The major projects of the Canadian Nurses' Association are centred on *Service* and *Education* and the activities are under the capable guidance of the Director of Special Studies. Her recent progress report on the various Studies was most encouraging. Recalling the master plan for action contained in the Mussallem Report, *Spotlight on Nursing Education*, we can take pride in the activities initiated to implement the first three recommendations. The Plan to study the whole field of nursing education (Recommendation I) which had to be postponed during the last biennium, has been reviewed and the study is now underway.

The School Improvement Plan (Recommendation II) is being carried on currently. Many interesting and valuable benefits have accrued to those schools participating. The truth of the old adage "the best way to help people is to help them help themselves" is abundantly borne out in the success of this program. The emphasis has been focused on identifying and strengthening those educational values which can be transferred from one setting to another.

The Evaluation of the Quality of Nursing Care (Recommendation III) requires some yardstick to measure the goodness in nursing, some better means of assessing quality, some method of appraising quality as a relative degree of goodness. The development of such a yardstick or criteria for this evaluation process has been a slow and arduous task. However, the Study Director reported recently that tentative criteria had been determined and that surveys would be undertaken in selected hospitals during this year.

Other professions are endeavoring to evaluate the quality of care rendered by their practitioners. As I believe it has some significance for nursing care I quote Dr. Caldwell Esselstyn's criterion for the evaluation of the quality of medical care: " . . . the degree to which it is available, acceptable, comprehensive, documented, and continuous, and, the extent to which adequate therapy is based on accurate diagnosis and not symptomatology."[3]

In carrying on the day-to-day activities of the Canadian Nurses' Association, the "secretariat" together with the various national committees are endeavoring to achieve, in some measure, the objectives set down in the 1962-64 Platform of the Association. It is a fair statement to say that the Canadian Nurses' Association is vigorously active in fulfilling its reponsibilities and obligations to its membership and to society. Without action obligations falter, intentions err, and ideas perish. The concept of nursing which we hold must be implemented, the purpose must be translated, if the ideals and attitudes of the profession are to be fulfilled.

"Whatsover things are of good report, . . . think on these things."[4]

E. A. Electa MacLennan
President,
Canadian Nurses'
Association

1. CNA Folio of Reports, 1960-62: Report of Committee on Nursing Education, p. 44.

2. CNA Folio of Reports, 1960-62: Report of Committee on Nursing Service, p. 39.

3. Masur, Jack, "The Quest for Better Hospital Care," *Public Health Reports* 77: 12 (Dec. 1962), p. 1037.

4. Philippians, 4:8.

The Emotional Aspects of Illness

JEANETTE MOSSING

An introductory seminar plan for junior students.

General medicine, and its specialty branch, psychiatry, emphasize the interrelationship of mind and body. Though treatment and care may be specifically oriented to either, the individual must be considered *in toto*.

Nursing education must utilize its opportunities to increase the knowledge, skills and understanding of those being prepared to assist in meeting patient needs. It must prepare the student for her role as a nurse in today's society as well as in the society of the future.

Much is being done to assist the nursing student to achieve a more dynamic approach to nursing. No longer do nurses educators teach that mind and body are separate, unrelated entities. Rather, they stress that nursing care should be directed towards meeting all of the patient's basic needs. An effort is being made to implement programs in nursing schools that will enable the nursing student to obtain a greater understanding of herself and her patients. It is no longer enough to say, when discussing a patient's illness and behavior, such things as "She is a middle-aged lady who is quite demanding. She will need much understanding and patience." The nurse must understand *why* the patient is behaving as she is, and *how* she can be helped.

Psychiatric affiliation provides learning experiences which help the student understand behavior. This experience may be given during the student's second or final year. Nurse educators have expressed a felt need for an earlier, more dynamic introduction to the emotional aspects of illness *prior to* this affiliation. Who would be adequately prepared to teach this? What methods could be used?

As one possible answer to this problem, a one-day seminar on "The Emotional Aspects of Illness," was conducted for junior nursing students from three hospitals in Saskatchewan. These hospitals sent their students to a general hospital psychiatric wing for this experience. The nursing instructors from the wing planned and conducted the seminars. This one-day program was included in the junior block lecture schedule. From the results of the day's experience, the individual schools could then decide whether or not to include it in their curriculum in succeeding years.

At the conclusion of three such seminars, a report was compiled and sent to each of the schools of nursing. This report briefly described the basic concepts used as a foundation for the teaching approach, the objectives of the seminar, the outline, interpretation and results of the plan.

A one-day experience presents insufficient evidence for generalizations to be made. The results did prove, however, that there was a *felt need* for this approach. It brought a positive and enthusiastic response from the participating students.

The Seminar Plan

Each school has different needs. It would be advisable for a school considering implementation of this plan to formulate its own objectives, outline and methods of approach to meet these needs.

Three basic ideas had to be considered: The patient's concept of his

role as a sick person; the nurses' concept of her role as a nurse; and common problems in nursing. Excerpts from the report to the schools include:

Basic concepts

As a foundation for the approach to this seminar plan, two basic concepts were formulated:

1. Human values, human perceptions of behavior and human behavior itself are determined largely by the individual's immediately experienced personal needs whether one is in the role of the patient or of the nurse.

The patient immediately experiences the pain, the discomfort and anxiety that attend illness. He values those activities that, in his perception, most directly help to alleviate these tensions. The nurse may sympathize or even empathize with the patient, but she does not feel his experience directly.

. . . the nurse directly experiences her psychological need to help others, her desire to use her knowledge of the physical and social sciences, and her identification, through her nursing education and experience, with the profession of nursing. She values the activities that fulfil her needs. The sensitive patient may be intellectually aware of the nurses' needs and interests, but he does not feel them directly.*

2. All human values, perceptions of behavior and behavior itself, are determined largely by the physical and psychological setting in which an individual lives. As an example, an individual's concept of illness will be influenced by the hospital setting, the idea that the nurse is "the hostess" and the patient is "the visitor."

These two concepts are basic to an appreciation of the need, the approach and the implementation of ideas regarding the emotional aspects of illness.

Objectives of the plan

a. To orient nursing students to the emotional involvement in illness and its outward expression in patient behavior.

b. To improve the nursing care given by the nursing student in the general hospital.

c. To show the correlation between general nursing and the psychiatric viewpoint.

d. To provide an experience in caring for the mentally ill.

e. To promote greater personal insight and to aid the student in gaining greater emotional maturity.

Outline of the plan

10:00 A.M. — Introduction
10:15 A.M. — Patient's concept of his role as a sick person
11:15 A.M. — Reading period
12:45 P.M. — Buzz session: The nurse's concept of her role
Report and discussion
2:20 P.M. — Common problems in nursing
3:20 P.M. — Film. "Anger at Work"
4:00 P.M. — Questionnaire for evaluation purposes

Interpretation of the plan

a. *The patient's concept of his role as a sick person:*

Each individual's perception of this role is different. It is influenced by heritage, experience and socio-cultural environment. For example, a woman may bear pain silently because she believes it would be a disgrace to complain; another moans and groans regardless of the degree of pain since she believes that she has to assume the "proper" role of a sick person. A child may have found illness an attention-getting device. A man, proud of his masculinity, strength and fortitude, may protest strongly because he is subjected to a dependent state; a patient may act like a baby because he expects to be treated like one when he is sick. Factors such as age, sex, religion and income must also be considered.

Therefore, the nursing student may find that a patient is not always cooperative and friendly. It is necessary for her to develop insight into the various factors that influence the patient's concept of his role in hospital so that she will have a better understanding of the nurse-patient relationship.

b. *The nurse's concept of her role as a nurse:*

Frequently, it is found that a nursing student has a stereotyped image of a suitable bedside manner. This occurs

* J. Frank Whiting, "Patient's Needs, Nurse's Needs and the Healing Process," *American Journal of Nursing*, vol. LIX (May 1959), p. 661.

unconsciously even though she realizes certain qualities are inherent in a "good" nurse. As she progresses in her learning experiences she will find, instead, that flexibility and adaptability are two necessary tools in every nurse-patient relationship. Therefore it is important to discuss, freely and openly, the nurse's role.

The nursing students will gain insight by first looking at their own role. The buzz sessions proved invaluable for this purpose. The students' goals for themselves were very comprehensive and quite idealistic. We collected the information presented by the various buzz groups, (there should be from five to eight students in each group), and built up a standard of criteria which would describe a "good nurse." Following this, we were able to point out that most of these skills involved human relationships. We discussed the fact that this nurse-patient relationship has the power to influence the patient in a positive or negative way towards becoming well again. The nurse herself is a tool in therapeutic relations. True nursing involves skills of both heart and hand.

A cliché that "nurses are human too" impressed itself on our corporate thinking. The students realized that the nurse's own needs and expectations would effect the patients' reactions to her. Nurses need praise, satisfaction, love and understanding. Therefore it is important to realize that we sometimes have conflict between our own expectations of our role as a nurse and our own needs.

c. *Common problems in nursing:*

The discussion of the nurse's role and the patient's conception of his role, provided a background for the dynamic approach to the third area of discussion: common problems in nursing.

The nursing student is taught that a patient brings fears and anxieties with him when he comes into hospital. She has probably had an opportunity to observe and experience this in her contacts with patients. However anxiety, fear and other emotions are not always obvious in a patient's behavior. It was the object of this phase of discussion to have the students share with classmates their experiences with "troublesome" patients, and to discuss problems they had already encountered when caring for them. Generally, these problems involved patients who were demanding, anxious, depressed, self-depreciatory, senile, uncooperative, or facing death. (The general consensus was that the favorite patient was the cooperative one). The examples presented were similar from all schools. They were discussed individually or collectively: e.g. "He was never satisfied." or "They expected us to jump at their beck and call." It was important, in this discussion, to help the students look for the underlying cause of such behavior. Insight, for one student, was expressed in this way:

> When he bosses us around and acts as if he owns the hospital, he is perhaps frightened and insecure underneath and doesn't want to lose control of the situation. Next time I meet a "problem" patient I won't be so quick to judge him.

A difficulty exists in teaching this aspect of illness to junior students. The interpretations and terminology must be in simple, everyday language, practical for daily use, geared to their level of knowledge and understanding. This seminar was only an introduction to the emotional aspects of illness; it served to increase the student's basic understanding in order to give better nursing care to the whole person. The seminar itself was oriented to encourage discussion, employing group work rather than the didactic method.

An extensive bibliography was prepared from nursing periodicals. It served two purposes:

> First, to create interest in the reading material that is available for nurses and nursing students.
>
> Second, to allow the student to discover for herself a written source of information concerning the emotional aspects of illness. There were enough articles listed to provide one or two reading references for each student.

The film shown was one prepared for industry. It proved effective and entertaining as it presented the topic concerning displacement of anger. An objective example in another field of endeavor often teaches more effectively than one related to nursing itself.

Evaluating the Results

Some means had to be devised to evaluate the students' reactions to their one-day experience. A questionnaire was prepared which they completed at the end of the day and the results were tabulated. The home schools were then able to review the questionnaires and determine the value of the project.

This seminar is only one approach to meeting a felt need. No estimate can be made to accurately determine the results. Nursing care may have improved but nursing care is influenced by many other factors which will contribute to, or deter from, improvement in the student's performance. The effect of the approach and the results obtained are influenced also by the fact that the group discussion method may have been a change from usual classroom routine; the subject was of interest and concern and had a practical approach; and the students were taught by a different instructor. The students suggested longer periods including a problem-solving period as part of their learning experience, more time to spend on the bibliography material and more group discussions.

The question was, "How can we help the nursing student to understand the emotional aspects of illness early in her learning experience?" One possible answer has been suggested here. Any plan must be flexible and adaptable to the felt needs of the group concerned.

In The Good Old Days

(*The Canadian Nurse* — MAY 1923)

To date, a sufficient number of cases have been observed to justify the statement that insulin given subcutaneously will remove cardinal symptoms of diabetes within a very short time for a period of several hours. To suppress the symptoms permanently, however, the injections must be repeated, the practice at present being twice daily; whether the diabetic condition is in any degree cured by the rest which is given to the damaged pancreatic function cannot as yet be stated.

Government reports show that in 1921, 15,000 deaths occurred from diabetes mellitus in the registration area of the United States, ranging from 21.8 per 100,000 population in New York State to 6.4 in Tennessee.

* * *

The report sent (to the *Journal*) from the Public Health Committee of the Association of Registered Nurses of the Province of Quebec . . . puts strong emphasis on the great value of general open meetings for all members of the association: "This cooperation between the public health group and the general body of nurses indicates a most desirable trend in the nursing profession. While specialized groups need to meet together to discuss their own particular problems, it would be disastrous if any one group became isolated from the interests of the whole." Disastrous indeed if we ever get to the state of mind when we do not recognize the close interknitting of all branches of nursing, and the need for general discussions of all these in general nursing meetings . . . No one branch of nursing can afford to stand aloof, but every effort should be made to show the need for a better understanding of the public health requirements of our people in the training school and among the private duty nurses.

* * *

The first lesson the probationer learns is that of implicit obedience to all orders given by the physician, superintendent, or head nurse. Next, she must learn deference, honor, and loyalty to her officers; and last, the great lesson of professionality.

The Role of the Teacher-Counselor

MARY M. CONROY, B.SC.N.

In small schools of nursing, the clinical or classroom teacher very often has to assume the dual role of teacher and counselor. This article concerns the role of the teacher in the counseling program and in her private dealings with students.

Schools of nursing and teachers therein

have come to accept the philosophy which imposes on them the obligation to consider the student as a whole — her intellectual capacity and achievement, her emotional makeup, her physical condition, her social relationships, her vocational skills and aptitudes, her moral and religious values, her economic resources, her aesthetic appreciation. It puts emphasis on the development of the student as a person rather than on her training alone.*

As teachers in schools of nursing our aim is to foster

the ability of the student to feel comfortable and satisfied about herself, her home and family, to get along with others, to contribute in a spirit of cooperation and goodwill to the necessary activities of the school.†

These authors express in clear and concise terms the attitudes and the aims of the modern school of nursing.

The more common emotions evidenced by pupils in a school of nursing, which lead to problems, emphasize the importance of these attitudes and aims. A general plan can be evolved by the teacher in order to encourage the students to work out their own solutions to their problems.

How does the teacher uncover emotional and behavioral problems in the students? The nurse-student may come to her voluntarily; the teacher may learn from ward reports that the undergraduate needs help; the teacher may herself have observed signs of emotional conflict within the student. She may do this by observing the girl with her companions, from her comments, her appearance, or from comments of others. Informal contacts, where the teacher may come to know the student personally, may be between classes, on the wards, or at social functions.

Suggested steps in dealing with student problems include effective planning prior to the conference, such as consulting all available data regarding the student and lining up all information pertinent to the discussion such as progress or efficiency reports, examination marks. A pleasant remark and a friendly smile will help the student feel more at ease, and a brief casual conversation on some topic of interest to her will help establish rapport. If the teacher has requested the interview she will introduce the problem; if the student has requested the conference she will usually bring up the topic. The main thing is to help the student see the problem clearly with all its ramifications, identify what needs to be

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* *Student Personnel Point of View*, American Council on Education, Studies Series 1, volume 1, (June 1937).

† Norma Fenton, *Mental Hygiene in School Practice*, Stanford University Press, 1943, p. 63.

done, and then to work out her own solution with guidance from the counselor. In this way, the student nurse's thoughts and actions are gradually guided to the point where she comprehends mature behavior and is willing to cooperate in developing it in herself.

Emotional States

All emotions may be classified into three major groups: anger, fear, and pleasure or "love." All other emotional states are variations and combinations of these.

Anger is the general term under which a great many emotional states, from mild annoyance to towering rage, are classified. Anger occurs when an individual is frustrated and has no other means of reducing this tension. A student is more apt to become angry when she is fatigued, in poor health, or under tension. When she is subject to conflicting demands, needlessly strict supervision, or is compelled to perform the same act over and over again without any sense of achievement, irritations and resentments are likely to develop. In relationships between the person in authority and the student, care must be taken to avoid needless restraints, inconsistent demands, and correction of the student when she is angry. Above all, the teacher or supervisor must curb her own feelings of anger.

The second group of emotions, fear, include all states ranging from paralyzing terror to mild apprehension. Some psychologists claim that all fears have their basis in some traumatic experience in childhood or some danger experienced in the early years. Explanations and forewarning are two of the best ways of forestalling and alleviating fears. Especially in schools of nursing, new experiences are upsetting and fear-provoking if not properly explained to the undergraduate. The teacher-counselor has to be alert to deal with situations *before* they arise if possible. Initiating the student into a new situation by degrees, with frank discussion of it, is an excellent method of minimizing fear. Standards that are impossibly high at any given level of her education, may result in continual failure and undermine her self-confidence, ultimately resulting in fear. John J. B. Morgan, in his book *Keeping a Sound Mind* says, "The only way to master a fear is to discover what it is that caused the fear and to meet that situation adequately."§

Emotions included in pleasurable states vary from exhilaration to quieter sensations and satisfactions. Feelings of pleasure, generally speaking, are the result of gratification of certain basic needs, such as hunger, thirst, and sleep. Gates, Jersild, McConnell, and Challman say "Pleasure is also frequently associated with free and unimpeded activity, the exercise of mental and motor capacities, and ventures into new experiences."‡ We frequently encounter this in schools of nursing when an individual feels that her life is too rigidly circumscribed, or allows her "joy of living" attitude to dominate her behavior to the exclusion of more practical considerations, such as studies. The capacity to enjoy life is desirable but it can become a problem if carried to extremes.

Mary Brown is a cheerful, pretty girl of average intelligence, well-liked by her classmates and seemingly well-adjusted to the nursing school. However, her busy social life was distracting her attention both on duty and during classes. Assignments were hurriedly done, or late, often both. She studied furiously the night before an examination, or not at all. She only just made a passing grade in all her subjects but, because of her cheerful, bubbling personality, was well-liked by patients and supervisors.

A look at her personal file revealed that she is the second of three girls in a middle class family. When she came to my office at my request, her greeting was friendly and sincere. After a few moments of easy conversation about the forthcoming formal dance, I opened the subject of her poor marks. She expressed concern and confessed that she did not know how to study. She had done so poorly that she had lost interest in the theory and made up for it by her infectious personality. The problem obviously was to help her acquire good methods

§ John J. B. Morgan, *Keeping a Sound Mind*, New York, The Macmillan Co., 1957, p. 65.

‡ Arthur T. Gates and A. T. Jersild, *Educational Psychology*, New York, The Macmillan Co., 1953, p. 105.

of study, and to help her see that a nurse must have a well-rounded education — theoretical and practical — as well as a pleasing personality. Under counseling, her study habits improved as the teacher helped her to organize her lecture notes and introduced some reading that would interest her. After she had kept a timetable of her activities, social and otherwise, for a week, she realized how much time she had been spending on social activities and how relatively little she spent on her studies. As she worked out a more balanced timetable for herself, and carried it through, her marks improved as did her interest in her work. Coupled with her engaging personality, these attributes have made her one of our best students.

Attitude of the Counselor

When dealing with the emotional and behavioral problems of student nurses, it is important to avoid an attitude of condemnation and feelings of disapproval. Behavior must be considered as an expression of some need, recognized or unrecognized. Our task is to help students to identify problems, formulate solutions, try them, and, following this, assess their results.

The Person as a Nurse by Florence C. Kempf reveals the attitudes the teacher-counselor seeks to promote in her students.

> Meet people halfway and expect to like them; but learn to like in moderation. Be eager to help people without judging them. Have faith in people without being gullible. Sympathize without becoming emotionally upset yourself. Face your own mistakes and dissatisfactions honestly so that a new beginning can be made and inner harmony can be achieved. Take your work seriously, but do not take *yourself* seriously . . . The integrating person has learned to maintain emotional balance, a consistently serene and happy disposition . . . She has a long view plan of how to accomplish what she considers important.//

As you think about these quotations, are they not also a good expression of desirable attitudes in the teacher-counselor?

//Florence C. Kempf, *The Person as a Nurse*, New York, The Macmillan Co., 1934, p. 182.

A $2,000 grant has been awarded to the University of Montreal by Pfizer Canada to support the University's publication of an international symposium on muscle research progress. Papers prepared by 81 scientists from 17 countries will be included in the symposium, published as special issues of the University's *Revue Canadienne de Biologie*. This unique and highly important symposium was organized and edited by Dr. Gaetan Jasmin and Dr. Eors Bajusz of the University of Montreal. Distribution is to be world-wide.

Dr. Jasmin, associate professor in the Department of Experimental Pathology and editor-in-chief of the journal, described the project as "our most ambitious effort to date and one which we hope will do much to acquaint scientists around the world with the latest developments in muscle research." While he had expected a satisfactory response, Dr. Jasmin said he was overwhelmed by the number of submissions, with even the Russians taking part. As a result, publication will be in two volumes instead of the one originally planned.

Among the countries represented are: Canada, U.S.A., U.S.S.R., Finland, Japan, England, Norway, Sweden, Italy, Switzerland, Hungary, France, West Germany, Czechoslovakia, Belgium, Yugoslavia and the Netherlands. The contributors, all of them world authorities on the subjects selected, have dealt with various aspects of skeletal and cardiac muscle research as related to the most urgent practical problems. The first special edition was published in French and English in February.

* * *

A Psychiatric Glossary, prepared by the Committee on Public Information, American Psychiatric Association, can be obtained by writing to the Canadian Mental Health Association, 5757 Decelles, Suite 303, Montreal 26, Quebec. Price $1.00.

This booklet fills a long-felt need: to clarify psychiatric terminology for the layman and especially for professional persons who require an operational knowledge of psychiatry. We believe that this book would be of value to any nurse — student or graduate.

STAFF EDUCATION

in the Operating Room

LOIS PERRIN

Staff education includes all the educational offerings planned for the personal and professional development of personnel.

Nursing is one of the few professions that demands ingenuity, on the part of its members, to adapt their learnings to a variety of situations — situations that seem to be constantly changing. This demand makes obvious the need for staff education programs that will include nursing personnel at all levels.

Value

Before agreeing to the formation of a staff education program, the administrator will want to know the main value of a well organized staff education program. Ultimately, *better patient care*. Personnel who have an opportunity to express their ideas and opinions concerning hospital policies and patient care, will take more interest in their work. They are being treated as individuals and will, in turn, be more likely to treat their patients as individuals.

Demonstrations, lectures, films and discussions regarding patient care, new drugs and equipment, will help to ensure *safe* patient care. The wise administrator will find that investment in a staff education program pays dividends.

Orientation to Operating Room

One of the important functions of the operating room supervisor is the provision of educational programs for the staff.

Introduction to the department presents an opportunity for the operating room supervisor to put her plans into action. The new staff member comes to the operating room following an over-all orientation to the hospital. She will need a more intensive orientation to this department.

A written outline of the orientation to the department should be established and followed. In using a written form, economy of time is accomplished and the efficiency of the department is improved. Listed on this outline would be items of general information, such as locker assignment, laundering of surgical uniforms, etc. Points concerning policies and procedures of the operating room would also be included. A copy of the outline should be given to each new staff member.

"The average individual likes to be welcomed to a job rather than thrown into it," wrote L. A. Appley in *Management, the Simple Way*. Security is a basic need that must be met if optimum performance is to be reached. If the worker is oriented satisfactorily she begins to relax and enjoy her work. A happy worker is more efficient and the high standards that are required for safe operating room performance will be met. Efficiency automatically leads to better service.

The in-service educational program follows necessarily and naturally after orientation is completed. Periods of instruction should be assigned during regular hours of duty. An organized, systematic approach to day-by-day problems is the most practical solution. While the supervisor provides the stimulus to learn, actual motivation must come from within the learners them-

selves. All staff members should have an awareness of their part in the teaching process. Various methods may be employed depending on the material to be presented and the facilities available.

Methods of Teaching

1. *Formal lectures :* These will cover the essential information regarding the organization and routines of operating room work. Included under this heading will be the classes given by the surgeons and house staff in relation to the surgery of various systems of the body. Correlated closely with this will be the explanation by the nursing staff of the equipment and supplies required for that surgery.

2. *Demonstration :* Such topics as operating table usage, fracture room equipment, sterilization of equipment and supplies, contaminated case techniques, emergency lighting and care during power shut down, lend themselves well to practical demonstration. It is important that in each instance a return demonstration is presented by the learner so that her understanding of the procedure and the principles underlying it may be evaluated.

3. *Picture guides :* This may include actual photographic stills, motion pictures or film strips.

4. *Procedure books :* These may be in the form of loose-leaf books or on special cards. Which ever form is used, they should be readily available for reference.

5. *Staff conferences :* These are directed toward the improvement of nursing service. Learning occurs through the sharing of opinions. The environment must be such that those participating will express opinions freely knowing that their ideas will be studied objectively.

6. *Study of records :* The nurse's responsibility for records that are an important part of operating room management, necessitates her familiarity with them. These include the work sheet, operation schedule, narcotic records, and accident reports. The legal aspect of operating room nursing demands careful attention to other items including consent forms, the accurate count of sponges, care of needles and instruments.

Safety from fire should be a primary interest and responsibility of all those in any way concerned with the operating suite. Continuing in-service education in respect to this aspect should build up a thorough understanding of all the possible hazards. The following is a useful guide to the information that should be given :

Nature of Hazards :

a. Combustible anesthetic agents;
b. combustible disinfecting agents;
c. electrical systems — shock and spark hazards;
d. electrostatic spark discharges;
e. flames and hot material.

Construction and equipment :

a. storage locations for combustible anesthetic agents;
b. importance of ventilation for gases piped to various areas;
c. ceiling suspended surgical lighting fixtures;
d. portable equipment such as x-ray, cautery, or high frequency apparatus.

Handling of Gases :

a. identification charts;
b. storage of containers away from radiators and steam pipes;
c. special precautions with oxygen cylinders;
d. clearing dust and dirt away before applying fittings to cylinders;
e. never permit oil near regulators, never touch cylinders with oily hands;
f. leave repair of oxygen equipment to those properly qualified.

The psychological and emotional care of a patient in the operating room is another possible subject with wide implications. How we receive patients, how we reassure them as to what is going to happen and why and what we say in front of them while conscious or anesthetized has tremendous bearing on their recovery. The relationship between psychological trauma and difficulties in reception of the anesthetic is real. Those patients who await their turn on stretchers are in need of good emotional supportive care. It is up to us to take care of this need.

There is an obscure but growing phase of in-service programs which should be mentioned. It is the provision of special experiences to develop potential leaders once they have been recognized. A program to broaden

and develop these people might include rotation through all parts of the operating room; and guided experience with all types of work and with all the personnel. They should be encouraged and guided into courses at universities that would help them to develop their abilities. They can be helped to procure financial assistance through loans and scholarships.

Every staff member has a responsibility to contribute to the life and work of the hospital during her period of employment. A well organized staff education program will help her to meet this responsibility.

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THE QUEBEC CURRICULUM for English Schools of Nursing

ANNA A. CHRISTIE, B.N.

Discussion and study led to curriculum changes in the English-language schools of nursing.

The new curriculum for English-language schools of nursing in the Province of Quebec was the result of many years of hard work, discussion and study by the members of the English Curriculum Committee.

Ten years ago, the Instructors' Group (English), not altogether satisfied with their material pertaining to curriculum, requested that an institute be held on curriculum planning. They were fortunate in securing the assistance of Mrs. Eugenia Kennedy Spalding, Teachers College, Columbia University, New York. Her contributions provided a great deal of motivation. In 1954, Miss Elsbeth Geiger was appointed chairman of the (English) Curriculum Committee, and in September of that year the members were named with representation from all English-language schools of nursing as well as certain public health agencies. A representative from the French Curriculum Committee attended the meetings.

In planning for the task ahead, the Curriculum Committee considered itself as a "Master-Planning" or "Core" Committee. Sub-committees were formed to work under the leadership of a member of the parent committee on a designated area of the curriculum. At each regular meeting the leaders of the sub-committees reported on the work

accomplished by their groups, and presented material for approval or for suggestions. This was a slow method of working. It involved many instructors who were not normally members of the Curriculum Committee but who were experts in their field. Many of the participants were new to the ways of curriculum planning. They learned slowly through experience.

In September 1956, a three-day workshop was held for all instructors with a view to finishing the curriculum. This aim was not attained. The workshop was very well-attended and participation in discussions was active and productive. A great deal was accomplished in Nursing Part II concerning the approach to disease. Basic concepts were set down for each of the pathological areas of "dis-ease." Plans were made to have the material revised and edited. Copies of the revision were prepared for each school of nursing. In March 1958, another workshop was held. The theme was: "Our New Curriculum and How We Use It." Many interesting topics were presented and provocative questions were raised. Through these conferences the Instructors' Group became directly concerned with the success of the project. The head nurses were included in the discussions at a "Head Nurse Day" in May 1958. They became familiar with the philosophy of the curriculum and its interpretation. Lively discussion followed the topic: "The Role of the Head Nurse in Nursing Education."

Gradually, our curriculum became more and more complete. We were fortunate in having on our committee a group of instructors who were willing and able to test sections of the curriculum in their schools. Reports of their successes and failures were helpful to us in proceeding further. We added Nursing Part III (Maternal and Child Health Nursing) and Nursing Part IV (Psychiatric Nursing), and finished course outlines, sample units and bibliographies in each area. We began to wonder if we should go back to the beginning and revise it all over again. It had been necessary, as each section was finished, to review what had been completed and make necessary adjustments. Since this process could be continued indefinitely we thought it wise to have the curriculum set up in print.

Curriculum Changes

1. *Today's nurse is concerned with the patient as a person.* An understanding of human behavior is vital to good nursing. In order to attain this end the nurse must study the characteristics of the society in which she lives and the nature of man himself. Formerly, little stress was placed on this interpersonal relationship of nursing.

2. *She is assisted in understanding herself and others through discussion, reading and study.* The environment provides security and yet is stimulating, challenging and thought-provoking. Formerly, there was no planned time for the students to study while on duty. In fact it frequently happened that classes were given in off-duty time.

3. *More emphasis is placed on the understanding of principles.* In the past, teaching stressed content and techniques.

4. *There is emphasis on the problem-solving approach to situations.* Nursing lends itself to this approach. Problem-solving involves: assessment of a situation; identification of nursing needs; formulation of a plan for nursing; the implementation of the plan; and evaluation of the results. Formerly, students were told *what* to do. Little opportunity or time was given them to develop their own initiative and to reason *why*.

5. *The nursing student today begins with patient-centred care.* This approach replaces procedure-centred nursing where the efficient performance of technical skills was the chief concern. It is only through actually nursing patients that the student is guided in the specific application of principles and concepts discussed in the classroom. It is recognized, however, that the use of the problem-solving approach in learning depends upon the kind and amount of supervision available, some continuity of assignment of patients, and freedom within limitations that are clearly defined and agreed upon by those in the clinical situation.

6. *There is less concern with numbers of hours of class.* Formerly, great stress was placed on numbers of hours devoted to subjects. While it is recognized that for registration purposes a minimum number of hours of instruction is necessary, the emphasis is now placed on the quality of the subject matter.

7. *There have been changes in course organization.* The present curriculum has in-

tegrated chemistry with anatomy and physiology. The social science courses, community organization and human growth and development are designed to develop in the student broader perspectives which will: deepen her understanding of human behavior and of personality; foster her interest in the many aspects of community life; and develop an awareness of the forces that bring about social change. Personal and community health, history of nursing and professional adjustments are incorporated into community organization. The practice of nursing is divided into four parts:

a. Introduction to nursing: This concerns the supportive aspects of nursing which are most fundamental and least complex.

b. The approach to disease: Six major pathological areas are used: congenital anomalies, neoplasms, invasions by foreign substances, trauma, degeneration and metabolic disturbances. This framework is used as a guide in elaborating on the patterns of disease or "dis-ease" — the term our committee prefers.

This area includes the principles of what was formerly known as medical and surgical nursing. Here, more than any other part of the curriculum, stress is placed on principles that can be applied by the student to any situation.

c. Maternal and Child Health Nursing: The concepts of obstetric and pediatric nursing are brought together into an integrated whole to help the student to provide family-centred care.

d. Psychiatric Nursing: This subject has concepts and principles that are basic to all nursing. It is a relatively recent addition to the nursing course in Quebec as in many other provinces.

8. Until the spring of 1957, Quebec registration examinations were conducted in two parts — Part I after one year was completed, and Part II when the remainder of the course was finished. During the first period it was difficult for the instructors to refrain from teaching specifically "toward the Part I Registration Examinations." Since 1957, registration examinations have been written only after completion of the three-year course.

The concepts of harmony, balance, interdependence, and unity, are themes that pervade the curriculum. They bring the various areas together into harmonious whole designed to prepare the student to give basic nursing care to *any* patient, to guide her to maturity and to assist her to become a good citizen.

Usefulness of this Curriculum

1. *To the school of nursing:* The Curriculum Committee feels that this curriculum can be adopted by any school of nursing that has a well-prepared teaching staff.

2. *To the instructors:* The organization of courses permits the teachers a great deal of latitude. The themes that pervade the subject matter are found in all of nature and should be easily understood. The instructor must be concerned with the total curriculum, not just her own subject matter; thus she is continually challenged to improve her methods of teaching. She must be endowed with industry, initiative and a great deal of imagination.

3. *To the Student:* The student is given the opportunity of nursing the "whole" patient and she is challenged to think for herself. She is helped to learn principles and to apply them in any situation. The subject matter should be more meaningful to her because of the integration of the courses. It is recognized that some students will have difficulty in understanding principles and concepts, especially in the behavioral sciences. Patience and encouragement will be needed.

There are parts of the curriculum that are not yet developed in detail. There will be revisions from time to time as new ideas and beliefs emerge. In this era of rapid social change, the nursing needs of society have changed. The nursing curriculum *must* attempt to keep pace.

If we would read the secret history of our enemies, we would find in each man's life sorrow and suffering enough to disarm all hostility. — LONGFELLOW

HYPERTENSIVE HEART DISEASE

SISTER MARGUERITE FRANCES

Relief of emotional tension is an important factor in control of hypertension.

Mrs. Black, age 48, entered hospital for medical treatment of hypertensive heart disease with angina pectoris. Her main symptoms were severe headache, chest pain, and extreme exhaustion. In addition, she was overweight.

History

The patient's health and general condition had been satisfactory until she suffered a coronary episode several years before while in the sixth month of a pregnancy. With increasing frequency she had suffered attacks of angina pectoris, dyspnea on effort, and exhaustion. She was finally advised to enter the hospital for treatment.

Her blood pressure on admission was 170/110. She had pain across the central part of her chest radiating through to her back. Physical examination revealed very little out of the ordinary excepting an elevated blood pressure and overweight. A history of heart disease could be traced through her family. Her mother had died of it at the age of 34 and her two brothers were also affected.

A heart specialist was called in on consultation and his impression was:

> Mrs. Black is suffering from early advanced arteriosclerotic heart disease; an old posterior infarction; hypertension with hypertrophy of the left ventricle; myocardial ischemia as seen in long-standing hypertension.

Laboratory Reports

Blood studies indicated that the patient had an increased serum cholesterol level — 456 mg. % as opposed to a normal reading of 140-250 mg. %. At discharge from hospital, it remained at 414 mg. %.

Prothrombin time was checked daily since Mrs. Black was receiving Dicumarol prophylactically against the possibility of coronary occlusion. As the prothrombin time reached ideal therapeutic levels, the dosage of Dicumarol decreased.

An electrocardiograph indicated that heart changes had occurred in the interval since Mrs. Black had had an E.C.G. previously. All other laboratory studies revealed normal results.

Treatment

The main objective was to lower her blood pressure. To accomplish this, several factors had to be taken into consideration: overweight; heart damage; emotional factors, etc. Therapy was instituted in accordance with these problems.

Serpasil, an alkaloid of Rauwolfia serpentina, was ordered for its specific value in lowering blood pressure through its probable action on vasoconstrictor and vasodilator centres, and on the cardiac regulatory centres in the hypothalamus.

Diuril, a diuretic, lessened fluid retention through inhibition of sodium reabsorption by the kidney tubules, thus contributing to control of tissue edema.

Peritrate, a compound related to nitroglycerin, combined with phenobarbital, provided vasodilatory action plus a sedative effect that helped to relieve Mrs. Black's coronary insufficiency and provide general relaxation.

Tuinal proved to be an effective bedtime sedative.

As mentioned previously, the patient was eventually required to take Dicumarol prophylactically. As a result, treatment with Serpasil had to be discontinued since there was danger of hemorrhage from the combined effect of the two drugs.

Mrs. Black's very high serum cholesterol level was cause for some concern. Several days after her admission, Mer-29 was prescribed. This preparation is purported to inhibit the formation of both serum and tissue cholesterol. One side effect worthy of particular attention is the tendency to produce a false, positive reaction for albuminuria. Instances have also been reported of nausea, vomiting, temporary vaginal bleeding and dermatitis.

A low salt, low cholesterol, low calorie (800) diet was ordered with several aims in view: lowered blood pressure and control of tissue edema through restricted sodium intake; decrease in blood cholesterol levels; weight loss. A marked drop in blood pressure certainly seemed to confirm the benefit of lowered sodium intake in hypertension. The combination of a low salt diet and the use of Diuril led to the administration of potassium chloride to maintain a proper electrolyte balance.

Viewpoints differ concerning the role played by ingested cholesterol in raising the serum cholesterol level. It would appear, in this instance, that diet had little effect in reducing the level and that Mer-29 carried most of the responsibility for the rather small drop — 42 mg. % — that occurred. Mrs. Black lost seven pounds during her three weeks of hospitalization which was considered satisfactory particularly since she was on bed rest and her metabolism was generally decreased. The loss in weight subsequently lessened strain on her heart.

Since rest was an important factor in this patient's care, Trelmar, a tranquilizer, was prescribed to help ensure relaxation, also medication to relieve her severe headaches.

Nursing Care

The main objective was to create a therapeutic environment that would help to lower Mrs. Black's blood pressure, thus delaying the onset of serious complications. Bed rest may have some beneficial effect, and it is usually part of the treatment for a patient with severe symptoms of hypertension. Accordingly, Mrs. Black was permitted bathroom privileges only and was bathed daily by the nurse. Every possible means to relieve tension were utilized. Since she received medication specific to rest and relaxation, her door remained closed to keep out noise; visitors were restricted. The nurse attending her was friendly and reassuring. Since family troubles placed a heavy tax on her emotions, which in turn had a marked effect on the level of her blood pressure, an effort was made to help her to accept her difficulties as calmly as possible.

Mrs. Black responded well to this plan for her care. Her headaches became less frequent; tiredness and exhaustion disappeared; she became friendly and cooperative and appeared to have better emotional control.

Since the peripheral arterioles may be constantly constricted in hypertension, careful note was taken of the condition of Mrs. Black's skin and lower extremities. She was encouraged to change her position in bed at intervals and received special back care to prevent pressure sores. Special care was given to her feet by immersing them in warm water, washing them with mild soap, patting them dry, and massaging them with a lotion.

Mrs. Black's blood pressure was checked t.i.d. and gradually showed a decrease, stabilizing, more or less, at 120/80. The last week prior to discharge she was allowed to sit up in a chair for a short period each day. The last three days she was allowed short walks in the corridor.

Teaching the Patient

Mrs. Black was a very active woman. She admitted that she went at tasks with vehemence, had three or four jobs going at one time and usually ended up by becoming so exhausted that she finished none of them. Her doctor tried to impress upon her that she had to learn to live within the limitations of her impaired heart. It was the nurse's duty to supplement the doctor's teaching to the best of her ability. Mrs. Black was encouraged to plan her work; to seek the assistance of her family in those undertakings too strenuous for her heart; to rest during the day for at least two hours; to meet home problems with a more optimistic outlook. This advice seemed to be taken with realization of its soundness.

Unfortunately the family troubles that continually harrassed and worried the patient, will continue to exist. Knowing that religion plays an important part in Mrs. Black's life, the nurse tried to make her realize that in it lay her strength; that becoming frustrated over situations was hardly a solution. Mrs. Black realized that she had to help herself and seemed ready to try.

Outpost Nursing Station

W. J. WOOD, M.D. *and* ANNA M. SWAIL

Another chapter in the story of the health care for Canada's Indian and Eskimo people.

Central Region is one of the five large regions into which Canada is divided for the administration of Medical Services, Department of National Health and Welfare.* The area covered consists of 800,000 square miles and includes north-western Ontario, the province of Manitoba and Central Arctic up to the 65th parallel. In this territory live approximately 40,000 Indian and 2,000 Eskimo people. Headquarters for the Region is in Winnipeg. It is subdivided into five zones, most of which have a hospital as a centre and a number of satellite health centres and/or nursing stations within a radius of several hundred miles.

An outpost nursing station is a four-bed nursing unit with living quarters attached, located at a remote reserve or Eskimo settlement. The staff consists of two registered nurses (at least one of whom should be qualified in public health nursing and one in advanced obstetrical nursing), a housemaid and a caretaker. The nurses are responsible, under the direction of the medical superintendent and the guidance of the zone supervisor of nursing, for meeting the health needs of the people in the surrounding community.

* The Directorate of Medical Services, National Health and Welfare, covers the Divisions of Civil Aviation Medicine; Civil Service Health; Indian and Northern Health Services; Quarantine, Immigration Medical and sick Mariners' Services.

God's Lake Nursing Station

This is a typical station but its story is somewhat more dramatic than most. God's Lake is 350 miles north of Winnipeg and about 200 miles from the zone hospital at Norway House. In 1947 three small log shacks were rented from the mining company: One to be used as a sick bay with one bed and one crib; the second as living quarters for the nurses; and the third for storage space and as a laundry. The buildings were not modern and the only connection between the clinic and the living quarters was a boardwalk at the

ANNA SWAIL

back. At that time 477 Indian people lived in the three settlements served by this station. The nurses travelled to these points by canoe in summer and either by dog team or bombardier (snowmobile) in winter. As well as adjusting to northern living, they had the monumental task of interpreting the medical and health services offered by the Department to people who had had little or no contact with the outside world.

Cradle board transportation

The program, at first, was heavily weighted by tuberculosis control activities. Convincing the people of the need for early professional care was no easy task. Up until this time their experience with hospitals and sanatoria had been most unhappy. Almost invariably patients who were sent out were in such poor condition that they did not live to return. The mine had closed down; the people were once again dependent upon trapping and fishing for their living. Nine of the 21 babies born at God's Lake in 1947 died.

That first year the medical superintendent and nurses planned to concentrate specifically on two items in the program: pre- and postnatal care and tuberculosis control. The former was the harder to accomplish. Indian women were not in the habit of having four or five days rest because they had had a baby. The first clinics produced little else but confusion for the people and frustration for the nurses. They did not understand the language of the band and the Indians spoke no English. As yet there was no interpreter who understood even the simplest medical terms. Gradually, however, by visiting homes frequently, doing some first aid, and caring for the simple ailments they were allowed to see, the nurses became known, accepted and trusted. It was then that their program began to take shape and move forward.

By the end of the second year, in addition to the in-patient program, the field work was covering most aspects of public health: Pre- and postnatal care, child health, immunization, environmental sanitation, and a host of other necessary subjects. One big drawback was the lack of space for clinics and group teaching.

Despite the hard work, long hours and constant repetition, the nurses were fascinated by the work. There was something different happening constantly, from minute incidents to highly tense ones. To illustrate, one such episode occurred shortly after the nursing station was equipped with a two-way radio-telephone providing direct communication between the nursing station and the zone hospital. The nurses admitted a very large Indian woman in labor. The pains were only a few minutes apart but it became evident to the nurses, upon examining the woman, that they were in trouble. A call was made to the Norway House Hospital. After a brief delay the doctor came on the air. Step by step he directed the nurses through the process of carrying to a successful conclusion a very difficult delivery. At other times the call might be describing an illness or asking for advice concerning some lesser problem.

"Treaty time" was the highlight of the year. Two or three airplanes arrived and disgorged the Indian Affairs representatives, a red-coated Mounted Policeman, and the medical and X-ray parties. Most of the Indian people were seen by the doctor and dentist; immunization injections were given to those who required them; chest X-rays were taken. Then each Indian was given his treaty money, $5.00. Following the payment there were games, contests and much visiting with friends whom they had not seen since last "Treaty time." The day finished with a dance.

In 1954 our new nursing station was opened at God's Lake Narrows, approximately 12 miles from the old

Mother and baby

mine site and the three log cabins. The new station is a fully modern one-story building containing a three-bedroom apartment for the nurses; a large living room; picture windows; stone fireplace; a gleaming modern kitchen that would grace any suburban home. The nursing station section is equally attractive with two large airy wards; a patients' waiting room; a dispensary; examining room and office; well-equipped bath and shower room.

There is a full-sized basement, half of which is divided into rooms for the furnace, laundry, and dry and cold storage. The other half is used for health education group work, with the use of films and other teaching aids; sewing classes; other meetings which pertain to the general welfare of the community.

Selected Statistical Data

God's Lake Nursing Station

	1948	*1958*	*1960*
Population	477	630	695
Births	21	23	47
Deaths	34	3	8
Admissions to Nursing Stations	26	87	107
Total treatment days in Nursing Station	121	544	359

"Fathers' Day" at Baby Clinic

Conclusion

What a far cry from our three small shacks of 1947 when the Indians feared or mistrusted the nurse and all she represented; when the attendance of five people at a clinic was considered excellent; when nine babies out of 21 died!

Coming!

IN

JUNE, 1963

Earn	— Mental Concentration: A Psychological Skill	Audy	— Learning to Live with an Ulcer
Young	— How to Use Agencies		
Gattinger	— Mental Retardation	Paulson and Millward	— Assessing Nursing Care Requirements in a Polio Unit
Faust	— Patient-Centred Diet Therapy		

Pattern of Decision-Making in Staff Rounds

PEGGY C. PIKE

An outline of the mechanisms involved in the pattern of decision-making in ward rounds at a psychiatric institution.

The Allan Memorial Institute of the Royal Victoria Hospital and McGill University, Montreal, is dedicated to the care of all types of mentally ill patients, to research, and to teaching. The making of decisions related to the aims of this 128-bed open-door unit is a continuous process.

It is reasonable to assume that staff rounds in a hospital setting would be one situation in which decisions concerning patient care, progress, and discharge plans would be made. Representative members of the hospital team are, at this time, able to compare, add and exchange information relative to the patient. Out of this flow of material his total picture emerges. Step by step, as the physical, emotional and social aspect of the patient's world are uncovered, decisions are arrived at, with gradually diminishing frequency, until the final one of discharge planning.

Members of the ward team are representative of the disciplines surrounding the patient. Each one, at some time, has contact with the patient; some, in addition, have contact with the patient's family. Surrounding the periphery of the permanent core of staff members are students: nursing, social work, occupational therapy, and medical, who may contribute information — and do so in varying degrees. Their roles are similar to those of their senior team members, in a minor key.

Authority in Decision-Making

The staff doctor is the central figure on the team. He is the final authority. The other members grant him this right, perhaps for two reasons — his position and his experience. There is a willingness to leave the final responsibility for decisions to him. He is the ultimate power, and as such, he is invested with the right to see that a decision is carried through. The consequences of the decision are, by unstated implication, his. His experience in psychiatry and administration is respected. The staff uses it as a guide for their actions, and as a source of deeper understanding and clarification of what they are trying to achieve.

In his role as leader, the staff doctor is bombarded with information. He becomes a selector, evaluator, and a distributor. He must discriminate between what is worth examining more closely and what is irrelevant. He then designates assignments in relation to his decisions. For example, he may decide that more information concerning a patient's home situation is necessary. His experience indicates the importance of this information, and he has the authority to ask the social worker to obtain it. The social worker is part of the organization directed toward the welfare of the patients. In accepting the authority of the staff doctor, she is fulfilling the expected role of a member of a cooperative system. According to Chester Bernard:* "Authority is another name for the willingness and

* Chester I. Bernard, *The Functions of the Executive*, Harvard University Press, 1954, p. 184.

capacity of individuals to submit to the necessities of cooperative systems." Staff rounds are made up of a group of people applying specific knowledge toward one goal — a united effort toward improving and maintaining the health of the patient.

The resident physician has less authority than the staff man in the making of decisions. He does, however, by accepted custom, assume leadership in the absence of the staff doctor. He is seen as the person who is responsible to the staff doctor, and, to a degree, responsible for the continuing activities of the other members of the team. He supports and makes decisions. Administration is one of his chief roles. In effect, he oversees and maintains the smooth functioning of the group especially at the assistant-resident level.

The assistant-resident is a collector of information, and a direct link between the patient and his staff doctor. His knowledge of the patient comes from all available channels: the individual himself, his family, and other staff members in contact with the patient. This material becomes part of the total outline presented at rounds for decision-making. The assistant-resident contributes to decisions, but makes fewer decisions than the resident.

The social worker's role relates more to the patient's family. As a result, she is the person with the most authority in this area. Her information is accepted and used as a basis for understanding the patient's home background. She has a greater knowledge of community facilities than other staff members. Thus, her contribution is important when making decisions related to the discharge plans for the patient.

The psychologist has a precise role within the team. She presents her findings from her own frame of reference, the psychological tests. Her information is positive in that she has no leeway once the test results are evaluated. However, she is free to suggest further testing, thus leading the doctors into making further decisions.

The occupational therapist is preeminently occupied with manual dexterity and observations thereof. Because she is trained in a specialized field, she too may recommend certain activities for the patient. In such a case, she is opening the way for decisions related to her aspect of patient care.

The nurse is an information giver. Her contributions may be factual, e.g., patient's weight, or observational, in relation to the patient's response to medication and treatment, or his ward activity. She may be able to report on the family-patient interaction if she sees them together in the hospital. The nurse expresses her opinion about the patient's ward reactions, and these opinions plus her observations are part of the collection directed toward decision-making.

It is evident that decision-making is, in the main, the prerogative of the doctor, and lessens or increases in ratio to his seniority or authority level. The other team members are important contributors. Their role in decision-making is increased when the decision is directly concerned with their own special field.

Staff Roles in Decision-Making

Frederick Bates, in his study of authority and decision-making in hospitals,† has evolved a classification of roles in decision-making, four of which appear to apply directly to the "ward rounds" situation. The legitimacy of individual right to make decisions, according to this study, is granted by others in relation to their acceptance of his role. To put it another way, when authority is sanctioned by custom or usage, the right to make decisions follows. The roles which can be related to rounds are:

1. Choice maker.
2. Recommendation maker.
3. Opinion expresser.
4. Information gatherer.

Choice maker

In the process of decision-making, someone has to make the final choice between alternative courses of action. In staff rounds, this responsibility lies within the sphere of the staff doctor. He is the receiver of information, suggestions and reports from all branches

† Frederick L. Bates, *Authority and Decision-Making in Voluntary Hospitals*, Sloan Institute of Hospital Administration, 1959, p. 33.

of medical services in the hospital.

Recommendation maker

The privilege of making recommendations belongs to all staff members. Each representative of his service presents material to the choice maker. In that the specialities of service cannot be totally appreciated by a non-member, its representative is the logical person to bring suggestions forward for decision-making.

Opinion expresser

This person has the right to express opinions and be consulted. It is the nurse who is most strongly involved in this category, for she must know what the plans for patient care are, in order to carry out her duties. In addition, her opinions of ward or patient situations have a strong bearing on the direction of decision-making. The remainder of the staff shares this role in varying and sporadic degrees. The psychologist, for example, moves in and out of this role as the need for further psychological information becomes apparent.

Information gatherer

These people are, as their title implies, collectors of facts, theories, and material needed to implement decision-making. In the hospital, this information is gathered by all team members for presentation to the choice-maker.

The roles outlined are related to the hospital setting, but cannot be stated precisely. Members of the team may shift from one to another or sustain more than one role at a given time.

Stages of Patient Progress and Decision-Making

The pattern of a patient's progress in hospital can be divided into four stages. Each one leads into the other as examination results, treatment responses, and over-all progress are evaluated. Throughout, decisions related to the changing aspects of the patient's needs are being evolved. Medications are frequently changed. The patient's readiness to go to occupational therapy has to be ascertained. Discharge decisions are worked on some time before the patient is prepared to leave.

There is a continual application of Bernard's terms of decision-making:** "When decision is involved, there are consciously present two terms — the end to be accomplished and the means to be used." As the patient responds to his hospitalization, the *end result* — improved health — emerges. Therefore, the *means* toward this state lessen in intensity. Hence the phenomenon of fewer decisions by the staff being necessary as the patient progresses.

Stage I

The admission of a patient starts in motion a planned routine: the admission history, laboratory tests, encephalogram, physical examination, and psychological tests. The results of this battery lead into a chain of decisions. A process of selection is started because there is an over-production of material. Some results are final; others may have to be repeated or elaborated; new ones may have to be decided upon. The preliminary treatment pattern is set in motion. This is the stage wherein the greatest number of decisions has to be made.

Stage II

Here, the patient's individuality emerges more clearly. As information concerning the patient's ward behavior, illness and reaction to the prescribed treatments is clarified, different plans may have to be made. Decisions, at this point, are lessening in number.

Stage III

The reports on the different tests and examinations have been completed. The pattern of treatment is usually well established. Decisions at this stage are mainly related to observations of progress. Should treatments be increased or attenuated? Are the medications adequate? Information gained from the patient about his own feelings is being gathered. This is continually evaluated and related to decisions about further care or discharge. Fewer decisions are needed to support the patient's progress.

** Chester I. Bernard, *op. cit.*, p. 185.

Stage IV

The final stage of hospitalization is directed toward his future. Decisions are related to his ability to work, the type of work, and the most suitable home situation. Eventually, the date of discharge is set and the last decision has been made.

Decisions that are made are all directed toward the preparation of the patient for a healthier future. Each member of the hospital team contributes to this end by virtue of his own background. As the problems are solved, the number of decisions, and the speed with which they are made, diminishes.

An Example of Decision Process

On admission to the hospital, Mr. Dennis was subjected to the data-collecting routine. His physical examination suggested possible neurological complications. The encephalogram was slightly abnormal. The patient's psychological tests consisted of the usual admission battery, and the results related to what was expected. The laboratory sent back blood and urine reports that were not within the normal range. The admission history taken by the assistant-resident opened many areas for further exploration.

This over-all view became the starting point for all the decisions related to future care. Discussion followed the preliminary results of the admission examinations. Out of it came the decision to repeat the blood and urine tests. Decisions were made as to what areas the assistant-resident should explore further. The social worker was asked to find out more about the patient's home situation. The nurse was asked to observe his interaction with others on the ward. It was decided to have the occupational therapist place him in a group setting to observe his interpersonal relationships there. According to his history, the patient had spent years doing skilled manual work. The occupational therapist was asked to test this manual skill in the workshop. In the meantime, the medical staff decided to further explore his neurological condition. A second encephalogram was ordered. The patient was placed on the medications deemed necessary at this time. All recommendations and opinions were considered by the staff doctor before he made any decision.

The next development in the program was a re-evaluation of his examinations. The encephalogram was abnormal for the second time. A third was ordered and a neurological consultation arranged. The blood and urine results were normal, so no further decisions for repeat tests were needed. The occupational therapist reported that the patient's manual dexterity did not attain the level expected in relation to his past history. She was asked to re-examine him for indication of further changes in this area. In view of the material obtained by the assistant-resident, the psychologist was asked to recheck the patient's tests for further information related to his parental figures. The social worker's report on the home situation was completed and no further exploration was needed. The over-all decision made at this time was that the patient's emotional and neurological problems were closely linked, and would have to be studied as one.

The third stage consisted of a concentrated effort to determine the severity of his neurological condition and in what direction it was developing. The patient's ward behavior and reaction to medications did not necessitate any decision for change. When the neurological examinations were completed, final decisions were made in relation to the findings and the best plans for his future.

Conclusion

Decision-making in staff rounds can be observed from three points of view: All members of the hospital team are actively engaged in the process, and relate their contributions to their specific training. All information is channelled upward to the staff doctor for final decision-making. The number of decisions is less, and the speed with which they are concluded is shortened, as the patient progresses toward discharge.

This is the final test of a gentleman: His respect for those who can be of no possible service to him.

— WILLIAM LYON PHELPS

The degree of a nation's civilization is marked by its disregard for the necessities of life.

— W. SOMERSET MAUGHAM

PROBLEMS!

DILEMMAS!

QUESTIONS!

THELMA PELLEY, B.A., B.SC.N.

In our attempts to divorce nursing education from service, are we ignoring valuable learning experiences which emanate from the demands of service?

Who among us can escape the omnipresent problems and dilemmas which beset us from behind and before and beget many vexing questions? From every direction we are being made aware of the problems in nursing and are being urged to apply problem-solving methods to search out the answers.

Hopefully and sincerely we believe that nursing students with a sound educational preparation will help provide the leadership that will guide us into the freedom of a new day in nursing. Surely, all would subscribe to the principle that a sound educational preparation is earnestly to be desired and is essential for those who will be expected to appreciate and assume the responsibilities and privileges of nursing in the future. But do we not need to clarify our thinking and reach a common understanding and definition of what is meant by sound educational principles? Frankly, the contradictory implications of current professional discussion and practice are somewhat puzzling and bewildering. Are we not too often evading the issue and tending to tacitly assume that conformity to high school and university practices is equivalent to an application of the same principles in education? Can educational principles be equated with particular methods and techniques? Can a five-hour day and a five-day week for nursing students be equated with sound principles of education?

Without minimizing the importance of providing a physical environment conducive to learning, does a similarity of environment necessarily ensure the same soundness of educational principles? Can we assume that high school and university systems have the final answers for nursing education — or even for their own programs of education? If so, why their probing questions and critical self-analyses? Can we derive our basic principles from the philosophy and purpose of our own profession rather than from another discipline? What constitutes a desirable education designed to prepare the student to understand and accept the privileges and responsibilities of citizenship and of the practice of nursing? What kind of experiences will develop the fundamental skills required for continued growth toward realization of one's full potential as a person and as a nurse practitioner?

Any educational program based on sound principles recognizes that it is the student who must learn; that there must be discipline in order to achieve success in self-directed learning, which essentially is the only learning. We know that no person can exercise self-disciplined freedom on the road until all who use the highway are aware of and accept the externally imposed discipline of traffic regulations. It is equally true that a certain amount of externally imposed discipline is necessary to assist students to know and to

enjoy the freedom of self-discipline in learning. We need to reassess our principles and methods of education in relation to the inherent necessity for discipline in any accomplishment. Are we effectively teaching the art and skill of learning? Are we helping students to think through the relationship and the application of the facts that we require them to learn?

Do we assume too easily that if we have sufficient educational directors and instructors with high academic qualifications, a well-planned, integratted curriculum, and a controlled program operating within an ideal situation, we will provide a sound education for students? How do we evaluate intangible, personal qualifications and the dynamic interaction of human personalities in the awakening of the student's interest, concern and effort? Does a theoretical knowledge of the laws and principles of psychology and sociology necessarily provide insight and understanding in human relations? Is knowledge equivalent to wisdom?

Are we always definite about what we wish to accomplish before we formulate our curriculum? How can we plan for and achieve a particular objective unless it is clearly defined? Must not sound educational principles be relevant to the purpose and scope of the educational program?

We readily subscribe to the criterion that ascribes professional status to a group of persons who share a common body of knowledge. The acquisition of such scientific and related knowledge is unquestionably one of the objectives of nursing education. But, do we always recognize that the mere acquisition of knowledge does not constitute true learning? Facts are the tools which education helps the student to know and use. Our educational programs should not be directed primarily toward the objective of helping the student obtain a body of factual knowledge and become efficient in the performance of particular skills. Much may be outdated before the student is ready to practise as a graduate. Rather the objective should be to provide a leadership that can fire the imagination, arouse the curiosity to question and to know, inspire the will to act, and then guide the students as they use available human and material resources and search out answers in relation to living experience in dynamic life situations.

A second criterion of professional status is the recognition and acceptance of a service obligation. A professional person is concerned primarily with providing a service to humanity. Presumably, we accept this concept, but herein is a further cause of dilemma. If our objective is to prepare students for practice in a profession which is characterized by a service ideal, why is there an almost fanatical concern to completely divorce education from the implications of service demands? Is it educationally and practically sound to guard the educational experiences of nursing students so jealously? Must the giving of a service, that is not related to a specific planned learning experience, be an exploitation of the student and detrimental to learning? Might it not be a valuable demonstration of the *ethos* of the profession, and as such become a sound educational experience? Is there any better way to make a student aware of and appreciative of the need for and privileges of professional service than to provide an opportunity for her to share actively in a service-oriented experience as a part of her total educational experience? Is it possible to centre the whole emphasis of the educational program on the student and her needs and have her emerge prepared to recognize and appreciate her privileges and responsibilities?

Is it inconsistent with sound educational principles to allow the student, at times, to face the stern realities of existing situations, to expect her to adjust, within the limitations of her experience, and to respond to human need as she is able and not as she would ideally desire? Is it necessarily inconsistent to make demands upon the student for self-giving, and perhaps some self-denial, within the framework of a sound educational program that is directed, controlled and purposefully oriented to a preparation for professional service?

Granted that acquisition of knowledge has an intrinsic reward, it is not the whole reward. Knowledge en-

riches and illumines the life of the learner, but if it is alive it imparts a glow to the lives of others and helps illumine the common lot of humanity.

Let nursing and nursing educators study the experiences of other disciplines, seek and evaluate all available resources, but be prepared to recognize that a mature profession finds its own solutions and makes its own decisions regarding its response to the implications of professional duty and privilege.

If our education is based upon sound principles, these will relate effectively to our philosophy and our objectives; we will prepare students to respond to the situation as is exists, and realistically think through to the answers to the everchanging needs of the society in which they choose or are required to serve.

Let us not be afraid to be realistic enough to tell students that, as nurses, "We are not here to play, to dream, to drift; we have hard work to do and loads to lift." Let us dare to be idealistic enough to affirm that there is joy in service. Let us demonstrate faith in our nursing students and believe that they are willing to give as well as to receive. Let us dare to provide experiences whereby they may apply sound learning principles creatively so that they will continue to educate themselves for and in the service that they will have the privilege to give.

Diversity in Activity

At the annual meeting of the CNA Executive Committee, held late in February, provincial reports showed considerable diversity in activities with certain problems causing major concern since they have implications for nursing in Canada generally. The same reports also displayed areas of common interest. There appears to be a general movement towards involving individual members more deeply in professional affairs. A number of associations commented on special institutes for district and chapter executive members or committee members. There continues to be concern about the future security of the individual nurse. In this respect, Alberta instituted a portable pension plan while Manitoba and Nova Scotia approved plans ensuring income replacement. Anxiety, related to the most effective use of nursing personnel and to the provision of qualitative and quantitative nursing service, was manifested in a variety of ways: Projected studies of nursing care, nursing education, nursing service and hospital staffing patterns; investigation of overlap in medical and nursing functions; plans for refresher courses; concern over budget restrictions by governments.

Both the profession itself and the public are questioning the present and future role of nurses and nursing in Canada. Many factors have combined to produce pressures: an increased program of hospital expansion; development of health insurance schemes with associated governmental control; advances in medical science and subsequent changes in patterns of treatment e.g. increasing demand for domiciliary care; the role of auxiliary personnel. Alertness to the implications for nursing within each of these is essential so that nursing may continue to control its own destiny.

ALBERTA

1. Portable pension plan for hospital employees and local authorities approved and instituted. Compulsory for all employees except married nurses in any institution subscribing to it. The latter group may join on a voluntary basis.

2. An institute for chapter presidents based on leadership development, public relations and nursing recruitment was held. Chapter representatives attend executive meetings.

3. Principles, scope and implications of

collective bargaining being made more widely known.

4. Formation of staff associations encouraged to promote nurse-participation in policy formation.

5. Supplementary general nursing course prepared for psychiatric nurses. Aims: To increase the supply of registered nurses in mental hospitals; to provide more effective utilization of psychiatric nurses outside the specialized unit.

6. Implications of a College or Council of Nursing under study by a task committee.

7. Survey of nursing education and nursing care projected.

8. An advisory committee to the Nursing Orderly Association with representatives from the three constituent bodies of the Alberta Medical-Hospital-Nursing Liaison Committee set up. Aim: To improve the preparation of nursing orderlies and provide better care for male patients.

BRITISH COLUMBIA

1. Revision of recommended personnel policies prepared, with inclusion of senior nursing positions.

2. Institutes for various groups and refresher courses for nurses wishing to return to active practice carried out with considerable success.

3. A meeting for chapter presidents was held in 1962 and plans have been made to repeat this on an annual basis. A similar meeting is to be held for district presidents. Aim: More effective participation in association work.

4. A joint committee composed of representatives from the RNABC and British Columbia Hospitals' Association has been set up to study common problems. CMA (B. C. division) has been invited to share in a study to determine what procedures presently carried out by nurses are medical.

5. A major problem is "the effect of budget restrictions on the quality of nursing care in all hospitals, and on the educational programs in the teaching hospitals."

MANITOBA

1. Fiftieth anniversary of MARN founding occurs this year. Special projects undertaken in observance.

2. Curriculum revision projected; emphasis to be on patient-centred approach to nursing care.

3. Committee on Nursing Service engaged in action-research activities related to criteria for the quality of nursing care. Hospital staffing requirements being studied by a joint committee.

4. Amendments to Registered Nurses' Act to be presented to 1963 legislature includes one referring to qualifications for membership in the Association.

5. Special committee on medical procedures to study medical procedures assigned to nurses.

6. University of Manitoba now offering postgraduate study leading to the degree Bachelor of Nursing. Four-year basic degree program to start in September 1963.

7. Group plan for disability insurance providing income replacement approved.

NEW BRUNSWICK

1. Conference for chapter presidents held in January, to be repeated with vice-presidents also invited to attend.

2. Committee on nursing education is preparing a curriculum for schools outside hospital control. No definite plans for its use as yet.

3. A joint committee — NBARN, N.B. Medical Society, N.B. Hospital Association representatives — to study overlapping of medical and nursing functions.

4. A major concern is the utilization of nursing personnel for patient care and lack of clarity in regard to the respective roles of nurses and nursing assistants.

NEWFOUNDLAND

1. Possibility of Memorial University establishing a school of nursing is under study.

2. Registration Committee established to handle all matters related to this special function of the association.

3. Several workshop sessions held on a variety of topics — planning a clinical program, preparation of examination questions, inservice education.

NOVA SCOTIA

1. Public relations counsel has been retained.

2. Revision of the minimum curriculum for schools of nursing undertaken following an institute on curriculum planning.

3. Group insurance plan providing income replacement approved.

4. Extremely active emergency measures program in effect. Special committee includ-

ing the nurse consultant for emergency planning set up to approve hospital disaster plans.

ONTARIO

1. College of Nurses and Provisional Council now legally empowered to assume responsibilities. Regulations being prepared for submission to Lieutenant-Governor-in-Council.

2. Development of machine-scored objective-type registration exams, a continuing project.

3. A two-day conference for district and chapter presidents had, as its aim, more effective participation in professional activities. Conveners of the various district and chapter membership committees also held a conference to discuss means of increasing general membership.

4. Commissioning of male registered nurses in the Armed Forces was discussed with federal authorities. There is to be no change in government policy at present.

5. The Department of Education has been approached concerning the possibility of an experimental project in nursing education within the framework of general education.

PRINCE EDWARD ISLAND

1. A survey to determine nursing service requirements was conducted in two hospitals.

2. Committee on Legislation and By-Laws undertook the study of legal implications for nurses performing medical procedures.

3. A request has been made to the Hospital Services Commission for a cost study of basic nursing programs. A detailed study of the entire field of nursing education is hoped for eventually.

QUEBEC

1. Projected amendments to the Nurses' Act makes provision for the inclusion of male nurses.

2. An attempt is being made to form a Joint Committee including representatives from nursing, Department of Education, Medical Association, etc. charged with study of the means to implement an earlier recommendation to have basic nursing programs established within the framework of general education.

3. Time of licensing examinations for English language candidates changed to reduce waiting period between the end of the course and licensing; similar change for French language students under study.

4. Refresher program in English and French prepared for use in the province as required.

5. Announcement of new basic courses in nursing:

a. Institut Marguerite d'Youville-4-year course.

b. University of Montreal — to offer a 2-year course for candidates already possessing a bachelor's degree. Unique on the North American continent.

6. Shortage of qualified teaching personnel a major problem.

SASKATCHEWAN

1. Changes in educational requirements for entrance to schools of nursing introduced; university entrance to be effective in 1965.

2. A guide for directors of nursing conducting orientation programs for inactive nurses made available.

3. Job description for a nursing service adviser formulated — next position to be filled in the provincial office.

4. Committee on Nursing Education studying psychiatric affiliation. Has completed the revision of "Requirements for Approval of Schools of Nursing and Admission to the SRNA" based on a shortened program for students.

5. Joint Committee on Nursing, Medical and Hospital Services revised conditions under which nurses may administer intravenous solutions; gave general warning that administration of anesthetics by nurses is not approved.

I never travel without my diary. One should always have something sensational to read in the train. — OSCAR WILDE

Men get opinions as boys learn to spell, by reiteration chiefly. — ELIZABETH BARRETT BROWNING

THE WORLD OF NURSING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

Penny Stiver Honored

When the executive committee met in Ottawa in February, it was for the last time with PENNY STIVER as their executive director. They kept one night free of business matters to pay tribute to her and wish her success with "The Croft," the gift shop she and CHRISTINE LIVINGSTON open in the Muskoka district next month.

It was a night filled with memories for Penny as each member of the executive recalled events of her life in CNA. Past presidents who couldn't attend expressed their sentiments in telegrams. On behalf of the executive, LILLIAN PETTIGREW (executive secretary of the Manitoba Association of Registered Nurses) presented Penny with an engraved silver tray. The Quebec Suite of the Chateau Laurier was the setting for the evening Penny Stiver said she would never forget.

Penny was to repeat these sentiments just two nights later when the executive secretaries gathered at La Touraine to express their deep appreciation of her help and assistance over the years. In presenting her with a gift of crystal, they too wished her success and happiness in her new venture.

World Health Organization

MARIA TITO DE MORAES of Portugal has been appointed Nursing Officer at W.H.O. headquarters in Geneva, replacing ELIZABETH HILL who has retired. Miss Tito De Moraes has been on the staff of W.H.O. since 1950 and has served in nursing programs in Syria, Iran, Guatemala and Brazil. Her most recent assignment before joining the staff of W.H.O. headquarters was director of the Higher Institute of Nursing at the University of Alexandria in Egypt.

The Health League of Canada

Nursing secretary THELMA PELLEY was the National Office representative to the 1963 Canadian Health Forum held in Toronto in March. The theme of the three-day forum was "Fitness Through Prevention." It included outstanding leaders from various countries and fields, including representation from the health professions and voluntary health agencies as well as health researchers and educators.

Students' Visit

We are always pleased to welcome student nurses to National Office. In February, the 150-member class of second year students from the Ottawa Civic Hospital School of Nursing came in two groups for a tour of CNA headquarters and to hear about association and national office projects. GLENNA ROWSELL, director of the CNA school improvement program, conducted both sessions with members of the nursing staff also participating.

1964 Convention

Although the 32nd Biennial Meeting

is not until June 14-20, 1964, it is not too early to start making plans. The following members were named by the executive to the program committee. Any suggestions the provincial associations might wish to have this committee consider should be in National Office not later than December 1963:

Mrs. Jean Newton, nursing secretary of the RNANS;
Miss Jean Lewis, president of the ARNN;
Miss Pauline Laracy, executive secretary of the ARNN;
Mrs. Phyllis Barrett, chairman, Newfoundland arrangements committee;
Sister Mance Decary, president of the ANPQ;
Miss Thelma Pelley, National Office, CNA;
Miss Gabrielle Charbonneau, chairman of public relations committee;
Miss E. A. Electa MacLennan, president CNA;
The Executive Director of CNA.

RNAO Chapter Meets

The Ottawa Area chapter of the RNAO held its monthly meeting in National Office in March when members of National Office formed the panel of guest speakers. The panel included, Dr. Helen Mussallem, director of special studies; Miss Glenna Rowsell, director of the school improvement program; Miss Justine Delmotte, secretary international program; and Miss June Ferguson, public relations secretary. Following the meeting, the members enjoyed a tour of CNA headquarters and refreshments.

CNA School Improvement Program

Glenna Rowsell, director of the program, has now held three-day workshops to develop educational objectives in hospital schools of nursing in Halifax, Sydney, Fredericton and Quebec City. The following dates for the workshops in Montreal, British Columbia, Manitoba and Ontario have been confirmed:

Montreal (English) May 21, 22 and 23.
Vancouver, June 5, 6 and 7.
Victoria, June 10, 11 and 12.
Winnipeg, June 17, 18 and 19.
Port Arthur, October 8, 9 and 10.
Sudbury, October 15, 16 and 17.
Toronto, October 22, 23 and 24.
Kingston, November 5, 6 and 7.
Toronto, November 12, 13 and 14.
London, December 3, 4 and 5.
Hamilton, December 10, 11 and 12.

U.S. Visitor

Miss Mildred L. Tuttle, director of the division of nursing, W. K. Kellogg Foundation, Battle Creek, Michigan, was a most welcome visitor to National Office April 17th. This was Miss Tuttle's first visit to National Office in over four years.

Here and There

Dr. Helen Mussallem was the keynote speaker at the 50th anniversary of the Registered Nurses' Association of Manitoba on April 25. Miss Justine Delmotte attended the RNAO annual meeting May 3, 4 and 5 as National Office representative. Executive Director Penny Stiver was in Montreal April 17 for the 23rd annual meeting of the Canadian Citizenship Council, and attended the 3rd annual meeting of the Canadian Centenary Council April 18, 19 and 20.

Some 50,000 ducks were banded at The Jack Miner Bird Sanctuary between 1909 and 1915. From 1915 to the fall of 1961, nearly 60,000 Canada geese have been banded and of these, 40,000 have been recaught.

All records and data are given to the federal governments of both Canada and the United States as well as to provincial and state governments. Copies are also sent to the biology departments of most universities. This information enables the governments to determine where any excessive kill takes place and what percentage is shot in each state or province. Thus, more rigid conservation laws can be enacted for certain areas.

— *The Jack Miner Bird Sanctuary*

NURSING EDUCATION

the Chief Topic in Ottawa

JUNE FERGUSON

You can always rely on CNA executive meetings to provide stimulating discussions with considerable food for thought. The meeting held in Ottawa in February was no exception.

In the chair for this first meeting of the 1962-64 executive was President E. A. ELECTA MACLENNAN (director of the school of nursing at Dalhousie University) who guided the 35 nursing leaders from across Canada through a seven-page agenda. During the three days, 22 reports from the committees within CNA, as well as those from the provincial associations, were discussed and acted on.

Of special interest was the report from the committee on nursing affairs. Chairman KATHERINE MACLAGGAN (director of the school of nursing at the University of New Brunswick) offered for the executive's consideration this goal:

> The Canadian Nurses' Association concentrate its efforts on nursing education in such a way that within ten years the nursing service of Canada will be provided by nurses who are graduates of university and diploma schools of nursing in the ratio of one to three.

The goal would see the university and diploma schools of nursing administering and controlling the complete educational experience of the student. When implemented, nursing associations will look upon their responsibility as being in behalf of the two groups; will promote recruitment of able students for university schools and will recruit for diploma schools those students whose ability and/or interest indicates this form of preparation; will give assistance and support to changes in those university and diploma school programs which do not control the total education program; will give priority (in those communities where university programs are established) to university programs in the use of hospital and health agency teaching facilities; will give priority in bursary support to university students until the proper ratio is established; and will support an appreciable salary differential between the two groups in employment. The goal, its definition of terms and its implications were adopted by the executive.

The role of the university school and recruitment were also topics for discussion when MARY RICHMOND (assistant professor of nursing at McGill University) presented the report of the committee on nursing education. She stated it was the feeling of her committee that there was need to examine the present roles of the university schools of nursing and to identify their future responsibilities. She also pointed out there was need to not only recruit suitable candidates into appropriate programs, but to define to the public, to counsellors and to prospective students, the nature of the differing programs. Her report requested the executive to explore the need for preparing and implementing in Canada a system of pool examinations for provincial nurse registration since National League test pool examinations were not available for French language students. It was agreed by the executive that Miss Richmond's committee should proceed with this study.

Of special interest, too, were the progress reports of the special studies group in National Office. For some time now, three projects have been evolving under the direction of Dr. HELEN MUSSALLEM — the study of nursing education, the school improvement program, and the study on a program for the evaluation of nursing service. Dr. Mussallem informed the executive that since her last report she had completed the field work for the study of nursing education in Canada for the Royal Commission on Health Services and now that the 28 studies for the Commission were being completed, it would seem advisable to re-examine the

original plan sponsored by CNA.

It will be remembered that originally CNA requested Dr. KASPAR NAEGELE to undertake an extensive study on nursing education. Arrangements had also been made for him to conduct such a study for the Royal Commission. Ill health prevented him from conducting either and Dr. Mussallem was requested to undertake the one for the Commission.

Dr. Mussallem suggested that in the light of present studies in the health field Dr. Naegele be asked to review the briefs and transcripts of the Royal Commission to determine whether the original plan should be altered; that by the end of the summer he have prepared for CNA a statement of the need for further study, and if required, submit a plan for it. It was agreed that the project should proceed on this basis.

In bringing the executive up-to-date on the progress of the school improvement program, director GLENNA ROWSELL reviewed the program since its inception in March 1961. Significant is the fact that 168 hospital schools of nursing out of a total of 171 are now participating. During the last year 18 conferences were held across the country to interpret the program to key people in the health and educational fields. Between now and next December 22 workshops will be held to develop educational objectives in basic educational programs. Director Rowsell suggested that following these workshops an evaluation of the total program be considered before further steps are taken.

The progress in the program for the evaluation of the quality of nursing service was reported by LILLIAN CAMPION. To date she has conferred with colleagues and experts in nursing and research; has reviewed related literature; has established criteria with the assistance of the advisory committee; has tested criteria in a Toronto hospital; has drafted a preview questionnaire; and has carried out some preliminary work on observation guides. A pilot survey will be made in the next month or so and a detailed plan for individual surveys then prepared. The surveys, which are scheduled to commence in September, will be limited to nursing service in hospitals with the observation of direct nursing care restricted to medical-surgical units. The department of National Health & Welfare will be asked to advise and assist in the section of a sampling of hospitals and visits will be made to the Canadian Medical Association; the Canadian Hospital Association; provincial medical, hospital and registered nurses' associations in those provinces where surveys will be made; and to each participating hospital, to interpret the project.

Discussions on education continued with the presentation of the executive director's report on the course in nursing unit administration. The executive was gratified to learn that the course, jointly sponsored by the Canadian Hospital Association and the Canadian Nurses' Association, has 400 students enrolled in this its second year. Indications are that the course, designed as an in-service educational program to assist head nurses and directors of nursing unable to attend university, and financed by W. K. Kellogg funds, is meeting a felt need. The course is given in French and English and two-thirds of this year's students are married and 40 years of age.

The meeting took on a lighter tone when the 32nd biennial meeting came up for discussion. Mrs. PHYLLIS BARRETT, chairman of the arrangements committee of the Association of Registered Nurses of Newfoundland, presented her report with such enthusiasm that one had to realize that the convention was not being held next month but a year from now. Tremendous strides have already been made in preparing for a great welcome to Newfoundland. "We can hardly wait," said Mrs. Barrett. The ARNN has been extremely active since it was announced the meeting would be held in St. John's. The dates of **June 14th to 19th** have been confirmed and transportation facilities, as well as pre-and post-convention tours, are now being explored. The discussions also encompassed the 1966 convention when the invitation of the Association of Nurses of the Province of Quebec to hold the 33rd biennial meeting in Montreal was accepted.

The last day of the meeting brought with it the announcement that Dr. Helen Mussallem would be the acting executive director until a new appointment was made. Her first official function in this capacity will be to accompany the president to the meeting of the International Council of Nurses in Geneva in August and to attend the Red Cross International Study Centre in Lausanne following the ICN board meeting.

Before the close of the three-day meeting the executive voted a grant of $20,000 to the newly incorporated Canadian Nurses' Foundation and a $2,000 donation to the International Council of Nurses . . . a happy note on which to end a meeting.

Wanted: Many Teachers

DOROTHY WARNER

"St. John Ambulance? Oh, yes. They teach first aid." It is a typical response. Most nurses don't associate St. John Ambulance with the teaching of home nursing — and thereby hangs a tale, this tale!

St. John Ambulance has an excellent home nursing course developed by Canadian nursing authorities. A great many women across Canada would like to take it. But good instructors are necessary, and, as St. John insists on the instruction and examination being done by registered nurses, the number of classes organized depends to a large extent upon the willingness of nurses to give a bit of their spare time to this public service.

St. John is grateful to the many nurses who already help in this way. Many more are needed. Let's take a look at the reasons why teaching a St. John home nursing class can be a rewarding experience for a nurse.

It is a special service which only nurses can give — sharing their knowledge with others who are eager to learn. There is no thought of making nurses out of the women who take these courses. All that they want is to become more skilled and resourceful in caring for their own sick at home, more ready to face emergencies.

It is a wonderful way, also, to help teen-agers and young women get a taste of nursing and find out if they would like to enter into nursing as a career. Teaching a St. John home nursing class is one of the best ways of recruiting for the profession.

And of course it is very good experience in teaching — and most nurses have to do some teaching. Health teaching is part of a nurse's job and with a St. John class of 15 or so she can reach far more people — quickly and effectively. A considerable part of the St. John course is positive health teaching.

Nurses who become interested in a St. John teaching assignment usually find that it can be done conveniently in their own community. St. John is taking its courses out to the residential areas by using portable equipment in community halls and schools in order to reach as many persons as possible, bring this knowledge to the family and fulfill its commitment to Emergency Health Services. Evening courses are sometimes held in the school of nursing classrooms in local hospitals.

Nurses who have taught home nursing classes have found it a satisfying experience. Usually, it involves one night a week for 12 weeks (two hour classes) but sometimes two nurses accept the responsibility for a course, sharing the teaching.

The St. John course teaches basic nursing: routine care of the patient, including bathing, back care, posture, etc.; how to recognize the early signs of illness; what to observe and how to report it to the doctors; how to prevent the spread of infection; the care of the convalescent, the chronically ill, the elderly patients; simple treatments which can be carried out in the average home; and so on. In a nutshell, the course teaches the essentials of keeping the family healthy and how to assist the visiting nurse or doctor when illness strikes.

In addition, of course, it provides a nucleus of trained people able to help in an emergency.

The question may be asked: "If nur-

ses do the teaching, what does St. John do?" It is a fair question. The answer is that St. John publicizes and organizes the classes, provides the texts for the class members and also a teaching guide for the instructor, arranges for the classroom and equipment, and provides those who pass with their certificate. The local St. John branch will do everything possible to make the nurse's teaching assignment pleasant and "smooth sailing."

With the shortage of doctors, nurses and hospital beds it is obvious that there is an increasing need for home care of the sick. This will be impossible without a much larger number of people who know some of the fundamentals of home nursing. St. John Ambulance would like to see someone trained in home nursing in every home by the Centennial year. It is an ambitious goal! St. John Ambulance recognizes this but it is worth shooting for. If Canadian nurses will share their knowledge by assisting with the teaching, it can be reached.

Nurses who feel that they would like to assist with the St. John home nursing course are invited to get in touch with their local St. John organization. Their assistance will be welcomed in communities large and small. Will you help?

In Memoriam

The Alumnae Association of the Royal Victoria Hospital, Montreal pays tribute to the memory of the following members: **Winnifred Almond** '12; **Mildred (Duder) Bradshaw** '13; **Mary (Pickard) Crawford** '22; **Louise (MacKenzie) Ferguson** '97; **Ada (Gladwin) Smith** '09; **Charlotte (White) Webster** '09.

* * *

Mrs. **Gladys E. Beardsall,** an Ontario nurse, died recently in Winchester, Ont.

* * *

Anne (Pullen) Burr (Royal Alexandra Hospital, Fergus, Ont. '28) died in 1962 after a long illness.

* * *

The Alumnae Association of the Lady Stanley Institute, Ottawa pays tribute to the memory of the following members: **Mary (Tubman) Patterson** '20 and **Edna Cochrane** '20. Miss Cochrane had engaged in public health nursing in Calais, Maine.

* * *

Nora McPherson (Rinker) Crawford (St. Joseph's Hospital, Hamilton '37) died in January, 1963. She had engaged in private nursing.

* * *

Annabel Dillabough, a retired Ontario nurse, died in February 1963 in Kingston, Ont.

* * *

Alice (Landry) Giroux (Victoria Public Hospital, Fredericton '05) died in Saint John, N.B. recently.

* * *

Florence (Hughes) Haines (Welland Hospital, Welland, Ont. '26) died in January, 1963. She had engaged in private nursing.

* * *

Linda Josephine Hayden (Wellesley Hospital, Toronto '23) died in January 1963 in Toronto. She had engaged in private nursing.

* * *

Viannia C. Ruth (Armstrong) Hornby (Grace Hospital, Toronto '31) died in January 1963.

* * *

Eudora May (Hunter) Leeson (Brandon General Hospital, Man. '01) died several months ago. She was a former superintendent of B.G.H., Nicholls Hospital, Peterborough, Ont. and Lady Minto Hospital, Cochrane.

* * *

Bernice (Butchart) Lougheed (Owen Sound General and Marine Hospital, Ont. '25) died in January 1963 in Veteran, Alta.

* * *

Sheila Doreen Madsen (St. Paul's Hospital, Vancouver '61) died in January 1963 as the result of a car accident. She was nursing in Fort Vermilion, Alta. at the time of her death.

Nursing Profiles

ROBERTA CUNNINGHAM

St. Paul's Hospital, Vancouver has announced two senior nursing appointments. **Betty Macnaughton,** a 1954 graduate of Vancouver General Hospital, is the director of nursing service. She obtained her B.Sc.N. from the University of British Columbia in 1960 and, shortly thereafter, joined the staff of St. Paul's as an instructor. Later, she succeeded to the position of associate director of nursing service, immediately prior to assumption of her present responsibilities. **Roberta Jane Cunningham,** graduate of St. Paul's Hospital, with her bachelor of nursing degree from McGill University and a Master's degree in nursing from the University of Western Ontario is director of the school of nursing. She has had considerable postgraduate experience in a variety of clinical areas including psychiatry, operating room and otolaryngology. Miss Cunningham is a long-time staff member of S.P.H., having served as staff nurse, head nurse and instructor.

Late last year, **May Fleming,** a graduate of St. John's General Hospital, Newfoundland celebrated her fiftieth anniversary since her entry into the nursing profession. She has given devoted service to her hospital down through the years in a variety of positions. Early in her career she filled the dual position of secretary to the medical superintendent and drug dispenser. Later, she became a ward supervisor and was eventually night supervisor for a four-year period. This was followed by four years as nurse in charge of the nurses' residence before Miss Fleming accepted responsibility for hospital records — work in which she is still engaged.

HAZEL MACDONALD

Hazel Rachel C. Macdonald has retired after 26 years of public health service. A native of Sydney, Nova Scotia, she studied home economics at Mount Allison Ladies College, Sackville, N.B. before enrolling in the school of nursing, Royal Victoria Hospital, Montreal. Following graduation, Miss Macdonald remained on the staff of her hospital in the maternity division for two years, then went on to secure preparation in psychiatric nursing at Johns Hopkins Hospital, Baltimore. Later, She studied public health nursing at the School for Graduate Nurses, McGill University.

In 1936 her career as a public health nurse began in her home town, Sydney; interrupted for a brief period of further

study in the United States. Miss Macdonald returned to become a supervisor of public health nurses in Cape Breton, retaining this position until 1956 when she was appointed supervisor of the Cape Breton Island North health unit. All who have worked closely with her testify to the enthusiasm and genuine love for people that have been characteristic of her personality. Miss Macdonald plans to live in her family home and is looking forward to an active role in community affairs.

DISASTER NURSING

JOAN SHAVE

As professional nurses, we have an important role to play in the health plans for a major disaster.

Disasters are not new to nurses. In every hospital they see the result of disaster affecting one or more families. Perhaps the head of the household has been involved in an industrial accident, or the mother in an automobile collision. To the family involved, this is a disaster. Multiply these single injuries by thousands or even millions, and we have a disaster of the size we are preparing for in the event of nuclear attack. In hospitals, doctors are within call; adequate instruments, medical supplies and medications are readily available. In a mass disaster, doctors may not be immediately available to direct or give specific orders. Nurses will have to exercise more independent judgment, and work with less direct medical supervision, and less equipment.

In a major disaster, nurses will provide care to the sick and injured. They will attempt to prevent and minimize illness and injury to the surviving population. The people requiring medical and nursing care following a nuclear attack may be categorized as *casualties* and *non-casualties*. The term casualties implies those who are sick or injured as a result of direct enemy action. This category would include persons with burns, traumatic injuries, radiation sickness, hemorrhage and shock. Non-casualties would be those whose illness or injuries are aggravated and increased in the chaotic situation. This group would include accident cases, and those with acute illness, chronic and communicable diseases.

In the event of a nuclear attack, nurses will be required to function in the following areas:

1. Emergency treatment centres;
2. Emergency hospitals;
3. Existing hospitals — expanded two, or three times their normal capacity;
4. Ambulance loading areas.

The nurse would function as a member of a team. This would provide maximum service with minimum staff. During the catastrophe, the health services will be augmented by a complex array of personnel. These persons will have different responsibilities and their preparation will vary. For those of us who survive the initial attack, the big problem will be public health in which public health nursing will play a vital role.

Il would be ideal if all assignments could be made according to the nurse's preparation. Most work will be assigned according to where nurses are, what needs to be done, and what they can do. Nurses should be prepared to extend their responsibilities in two directions:

1. In the clinical or treatment areas;
2. In the administrative and supervisory aspects of the patient's care.

To be able to assume responsibilities in the clinical area, the nurse should understand the fundamentals of first aid. She should also know the principles involved in nursing patients who

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have a variety of conditions. In a nuclear disaster, nursing care of patients may be classified as:

a. Those suffering from traumatic injuries which include wounds of varying degree, evisceration, amputations and fractures;

b. Those suffering from radiation sickness;

c. Those suffering from mental and emotional disturbances.

Nurses comprise the largest single professional group in health occupations. With the various categories of assistants, they constitute a great potential for casualty care. If the potential is to be realized, each nurse must be ready to assume her responsibilities.

The importance of leadership is well recognized in a crisis. The nurse leader requires the ability to be decisive, authoritative and directive. She should be able to work with others, minimize differences, organize and persevere. People turn to nurses in time of distress for reassurance, guidance and advice. A nurse's role has many powerful elements of leadership and it is her responsibility to recognize these elements. Her ability as a leader can only come from her self-assurance. This self-assurance depends upon her knowledge of what constitutes adequate care for casualties.

As a teacher, the nurse plays an important role in pre-disaster planning as well as in disaster situations. The principles of self-reliance must be developped by each citizen. One method of achieving this is through participation in the home nursing and first aid courses offered by the Red Cross Society and St. John Ambulance. One member in every family should be prepared in this way. Registered nurses are required to teach these courses and can be of service in this area. As prepared nurses, we should understand the organization, functions and responsibility of civil defence — especially the health and welfare services. Familiarity with the physical aspects of trauma and radiation, as well as the psychological and social consequences is essential. In the event of a major disaster, each nurse will be an important member of the health team. No matter what our personal loss, it is a part of our discipline to rise above our own grief and to accept the responsibility for which we are prepared.

PROFESSIONAL APPEARANCE

GAIL SAUNDERS

"The nurse's uniform is an insignia, a mark which spells devotion and service." Performance goes with the uniform and those who are careless about professional appearance are apt to be careless about other things.

Professional appearance begins with clean, healthy skin. Unlike an actress, the nurse appears to her patient as she really is. For duty, cosmetics should be limited to powder, rouge and lipstick, applied conservatively. A skin which is clear and fresh looking not only depends on thorough washing several times a day, but also on fresh air, physical exercise, sufficient sleep and a nourishing diet.

For the nurse to look her best, she must have clean, healthy hair that is free from dandruff. It is essential to have a neat hair style that is easy to care for, suited to the cap she wears and arranged off the collar.

The hands must be as well groomed as the hair in order to have a complete picture of an attractive nurse. They should be washed frequently with soap and water, rinsed in cold water and dried thoroughly. It may be necessary to use cream to overcome the drying effect of constant washing. No hands look well cared for if the nails are neglected. They should be cleaned and filed as often as necessary to keep them short and free of rough edges. Nail polish may be worn if it is colorless and applied well.

Clean white teeth add a great deal to personal appearance. A good brushing every morning, noon and night after eating, ensures healthy teeth and a fresh breath. The frequent use of a mouth wash is refreshing. The nurse should use a good deodorant and avoid the use of a heavily-scented perfume while in uniform. Nothing is more offensive to a sick person than the heavy, sweet odor of perfume, or the smell of "honest sweat."

It is important for a nurse to know where and how to wear her uniform. The standards governing the wearing of the uniform should be closely observed because they are characteristics of the nursing profession. "Wear it proudly, wear it right." It should be worn only in the hospital, not in the street. While on duty, a nurse is to be in complete uniform. The cap is a symbol of achievement and it should be worn proudly. It should always be neatly folded and clean; the pins and bobby pins used to fasten it in place should be concealed. The uniform must be spotlessly clean at all times. It may be necessary to change it or the apron during duty hours. A uniform of regulation length adds to personal appearance. If it requires repairing this should be done before it is worn again. Properly starched belts, bibs, aprons, cuffs and collars are a necessity.

In some hospitals the student nurses wear black nylons and black shoes on duty. Care must be taken to see that the stockings are without runs and the seams straight. The neat, well-polished black shoes add the finishing touch to the student nurse who wants to look professional.

Jewelry, other than a watch, should not be worn on duty. The nurse is not to chew gum nor smoke while in uniform. It is almost impossible to remove the smell of smoke from a uniform and some patients find it very offensive.

If a uniform is worn correctly and proudly, the nurse cannot help but act professionally. "Wear your uniform with pride and dignity as befits a member of a splendid and worthwhile profession."

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W. K. Kellogg Foundation

The Foundation's belief that "Education offers the greatest opportunity for really improving one generation over another," is tangibly evident in the financial assistance that it provides for this purpose throughout the world. Excerpts from the *1962 Annual Report* indicate that Canadian institutions and students have been among the many recipients of this assistance.

Dentistry: In view of the acute shortage of dentists, four western provinces passed legislation authorizing auxiliaries to perform additional dental functions. The Foundation agreed to support an experimental training program at the University of Manitoba relating to the addition of certain functions to the hygienist's role . . .

Other programs currently being assisted in dentistry include those at Dalhousie University, Halifax, and McGill University, Montreal.

Education: The Foundation is presently providing assistance to the University of Alberta, Edmonton. The objective is

> to aid pre-service and in-service programs for the improvement of educational leadership in Canada by strengthening the graduate program in educational administration at this University.

Hospitals: Greater hospital efficiency and better patient care are objectives that the Foundation attempts to achieve through its financial support. Hospitals receiving

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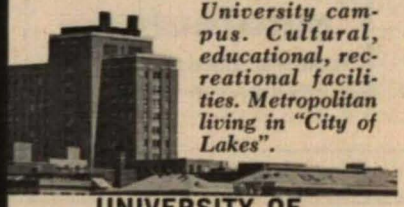

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assistance include the Associated Hospitals of Manitoba, Winnipeg, and the Belleville General Hospital, Belleville, Ontario. Educational programs in hospital administration are being supported at the Universities of Montreal, Saskatchewan and Toronto. The correspondence-extension program for nursing supervisory personnel, sponsored by the Canadian Hospital Association and the Canadian Nurses' Association, is another of the projects receiving financial aid.

Nursing: Grants have focused on the pre-service (basic), in-service, and graduate education areas.

Until recent years, there were no opportunities in Canada for nurses to obtain advanced preparation leading to the master's degree in nursing. New programs at the graduate level have been developed at The University of Western Ontario and at McGill University through the use of Foundation funds. The program at McGill prepares nurses for administration, teaching, and supervision . . . For the present, graduate nurse education at The University of Western Ontario is limited to the preparation of nursing service administrators.

The Foundation is also assisting the University of Saskatchewan with a certificate program in nursing service administration, having emphasis on the preparation of head nurses for ward administration. The University of New Brunswick is also receiving support with a new "non-traditional" four-year curriculum leading to the baccalaureate degree. The Foundation's financial assistance to a continuing educational program for nurses employed in New Brunswick, has met with considerable enthusiasm. The registered nurses of the province have asked for more of the same in the years ahead.

The Canadian Nurses' Foundation, established to provide fellowships to prepare Canadian nurses for leadership through graduate study at the master's and doctoral levels, is also a recipient of the W.K. Kellogg Foundation's funds.

Medicine and Public Health: Programs currently being assisted in these fields include: the undergraduate medical education programs at Dalhousie University, and the University of Toronto; graduate and post-graduate medical education at Dalhousie University and the University of British Columbia; the Association of Canadian Medical Colleges, Ottawa, Ontario.

It is interesting to note that the payments to these Canadian institu-

tions totalled $288,667. Nursing programs received the highest allotment — $91,817. Fiscal 1962 saw a landmark in Foundation giving, for the total of grants since its founding in 1930 grew to exceed the $100,000,000 mark. It is the hope of the Foundation's personnel, as voiced by its President and General Director, Emory W. Morris, that

> the majority of grants have been instrumental in improving the lives and horizons of peoples within the four continents which represents its geographic scope.

A second summer course on Alcohol Problems will be held June 9-21, 1963, at Queen's University, Kingston, Ont. The course will again be directed towards professional persons who are concerned with the problems related to the misuse of beverage alcohol. It is directed especially to those engaged in developing or supervising programs which aim at reducing such problems wherever they occur.

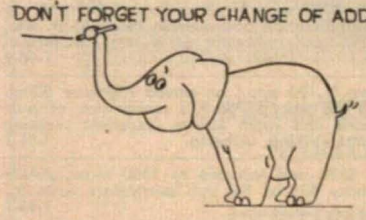
A broad range of professions were represented at the first summer course, which was held at the University of Toronto in June 1962. Included were: industrial medicine, psychiatry, nursing, social work, theology, education, psychology, and law.

Inquiries regarding admission should be addressed to the Education Department, Addiction Research Foundation, 24 Harbord Street, Toronto 5, Ontario.

* * *

He that would govern others first should be
The master of himself.

— PHILIP MASSINGER



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Nursing Arts Instructress and Clinical Instructress, applications are invited. For further details apply to: The Director of Nursing, Archer Memorial Hospital, Lamont, Alberta. 1-55-1

Registered Nurses for busy 44-bed active treatment hospital. Salary: $325 per mo. with bi-yearly increments. Excellent accommodation in recently opened nurses' residence. Medical and Hospitalization Group Plans. Liberal Holiday and sick schedule. Apply: Holy Cross Hospital, Box 339, Spirit River, Alberta. 1-81-1

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Registered Nurses (2) for active 35-bed hospital in progressive town (1,100 pop.) on paved highway 80-mi. east of Edmonton, Basic salary $325/m with 3 annual increments to max. $370. Full recognition of past service taken into account when determining starting salary. Board and room $30/m, excellent working conditions. Write or phone collect, Administrator, Municipal Hospital, Viking, Alberta. 1-91-1

Registered Nurses for new active 89-bed hospital. Starting salary $300 and increase to $350 max., AARN policy in force, new Nurses' Home with board and room and laundry $35/m. For full particulars write to: Director of Nurses, Municipal Hospital, Wetaskiwin, Alberta. 1-96-1

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Registered Nurses for General Duty for 37-bed Municipal Hospital, separate residence, Town of 1,400 population in South Central Alberta. Starting salary $300, yearly increases $15 max. $345, board and room $20/m. Apply in writing: Matron, Municipal Hospital, Vulcan, Alberta. 1-93-1

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General Duty Nurses. Starting salary: $300 per mo., 40 hr. work wk. Room, board & laundry available, if desired, at nominal rates. Civil Service holiday, sick leave & pension benefits. Apply to: Baker Memorial Sanatorium, Dept. of Public Health, Calgary, Alberta. 1-14-3

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General Duty Nurses starting salary $315, 9, $5.00 increases to max. of $360. Experience recognized at $5.00/year up to 3 years. Alberta Blue Cross and M.S.I. benefits. Please apply to: Mrs. P. Landry, Matron, Box 520, Fairview, Alberta. 1-37-1

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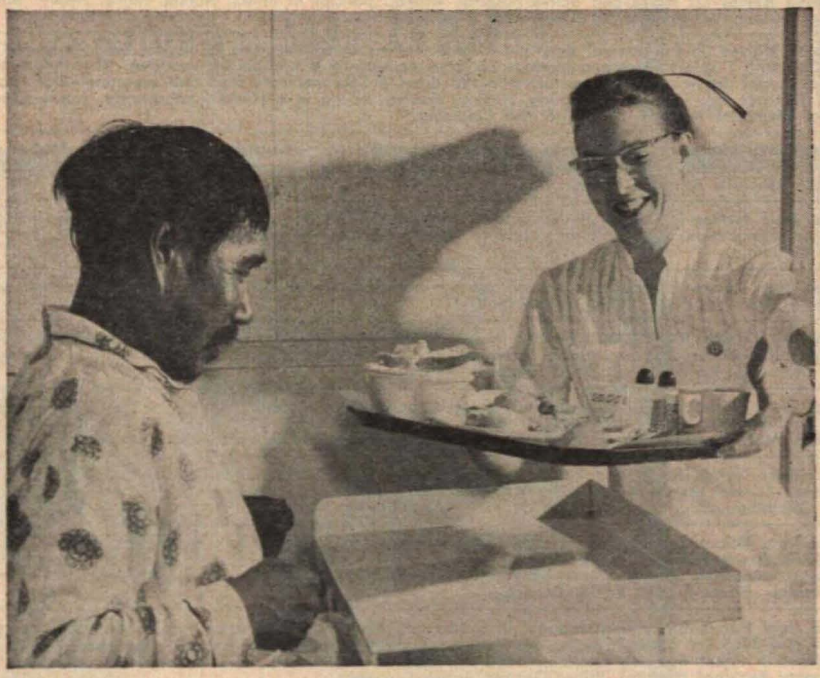

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Clinical Instructors (applications invited immediately) — Medical and Surgical areas. — Degree preferred but some university preparation essential. Excellent personnel policies. Apply, giving all particulars, to: Director of Nursing, Royal Jubilee Hospital, Victoria, British Columbia. 2-76-4

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General Duty Nurses for permanent staff and summer relief for 30-bed Fraser Canyon Hospital. Apply to: Director of Nursing, Hope, British Columbia. 2-30-1

General Duty Nurses for 200-bed General Hospital with School of Nursing. Salary range $320 to $387. Preplanned shift rotation, B.C. registration essential, 4-wk. vacation after 1-yr. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia. 2-32-1

General Duty Nurses for 27-bed hospital situated in the Scenic Fraser Canyon, 4 hours from Vancouver. Salary and benefits as per RNABC's agreement; $305 non-registered; $320 B.C. registered. Nurses' residence available. MSA Medical. Apply: Administrator, St. Bartholomew's Hospital, Lytton, British Columbia. 2-39-1

General Duty Nurses for 40-bed hospital. Salary for B.C. Registered Nurses $320-$387 & $305 for non B.C. Registered. Nurses' residence available. Apply: Director of Nursing, Nicola Valley General Hospital, Merritt, British Columbia. 2-41-1

General Duty Nurses for 110-bed hospital in northwestern B.C. Salary—B.C. registered $335-$402, non-registered $320. Newly furnished residence with T.V. Good social activities, including bowling, curling, tennis and year-round swimming. Full personnel benefits including travel allowance. Apply to: Director of Nursing, General Hospital, Prince Rupert, British Columbia. 2-58-2

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Graduate Nurses and Certified Nursing Assistants for 70-bed acute General Hospital on Pacific Coast. Salary for B.C. registered $309 with regular increments; unregistered $294; Nursing Assistants $205-$225. Board and room $25 per mo., 28-day vacation plus 10 statutory holidays after 1 year. Superannuation and medical plans. Apply: Director of Nursing, St. George's Hospital, Alert Bay, British Columbia. 2-2-1

Graduate Nurses for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic rate $320/m with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia. 2-9-1

Operating Room, Obstetrical and General Duty Nurses, British Columbia registered, for modern 450-bed acute General Hospital, located on South Vancouver Island. Basic salary $320, credit for experience & postgraduate preparation, personnel policies in accordance with RNABC. For particulars write to: Director of Nursing Service,St. Joseph's Hospital, Victoria, British Columbia. 2-76-5

Nurses two for 30-bed hospital. Salaries as per B.C. Registered Nurses' agreement. Comfortable nurses' home. Apply to: Miss H. Campbell, R.N., Director of Nursing, Community Hospital, Grand Forks, British Columbia. 2-27-1

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Graduate Nurses (4 or more immediately). Basic salary: $305 plus allowance for past experience. $5.00 increments every 6 mo. Separate residence with room and board available at $45 per mo. Free laundry of uniforms. Group insurance available. Apply: The Administrator, or, The Matron, The Altona Hospital District No. 24, P.O. Box 600, Altona, Manitoba. 3-1-1

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Registered Nurses for 100-bed General Hospital, salary $340 with four $10 increments, OHA pension plan in effect, good personnel policies, accommodation in residence if desired. For particulars apply to: The Director of Nurses, Lady Minto Hospital, Cochrane, Ontario. 7-30-1

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Registered Nurses and Certified Nursing Assistants for modern 64-bed General Hospital. Apply to: Director of Nursing, Arnprior and District Memorial Hospital, Arnprior, Ontario. 7-4-1

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General Duty Nurses for 100-bed modern hospital, southwestern Ontario, 32 mi. from London. Salary commensurate with experience & ability; $300 basic salary. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital, Tillsonburg, Ontario. 7-131-1

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Public Health Nurses (Qualified) for generalized program. Basic salary $3,900, good personnel policies, car expense allowance, hospitalization and Blue Cross 50% employer paid, group insurance and Pension Plan. Apply to: Dr. R. M. Aldis, Medical Officer of Health, Huron County Health Unit, Box 1060, Goderich, Ontario. 7-51-2

Public Health Nurse (qualified) for generalized program. Salary range $4,000 to $5,000. Car provided, pension plan, attractive personnel policies. Cost of travelling to Kenora provided. Apply to: Mr. D. T. McLeod, Northwestern Health Unit, Box 250, Kenora, Ontario. 7-64-3

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Night Supervisor for Shriners Hospital for Crippled Children, excellent personnel policies. Apply: Miss Flora M. Lamont, Administrator, Tel.: 842-4464, Montreal, Que. 9-47-42

Registered Nurses (2) for Summer Camp at the Young Men's and Young Women's Hebrew Assoc. Country Camp located in Huberdeau, Que., near Mont Tremblant Area. Attractive living quarters and infirmary. Doctor on Staff. Position from June 23, 1963 — August 23, 1963. Contact: Bernard Scotch, Camp Director, 5500 Westbury Avenue, YM-YWHA, Montreal, Quebec. RE. 7-6551 — Local 45. 9-47-55

Registered Nurses and Nursing Assistants for 110-bed hospital for tuberculosis and other chest diseases. Situated in the heart of the Laurentian Mountains, 60 miles north of Montreal. Good recreational facilities. Salary in accordance with the Association of Nurses of the Province of Quebec recommendations, with full maintenance, including private room in modern nurses' residence. 40-hr. wk., 8 statutory holidays and 4-wk. annual vacation. Apply: Director of Nursing, P.O. Box 1000, Ste. Agathe des Monts, Quebec. 9-57-1

Registered Nurses and Certified Nursing Assistants for modern 55-bed General Hospital, salary $300 per mo., 5 semi-annual increases, 40-hr. wk., 4-wk. vacation. **Certified N.A.** starting salary $210, 3-wk. vacation, accommodation available in new motel-style residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec. 9-52-1A

SASKATCHEWAN

Registered Nurse (immediately) for Union Hospital, Mossbank, Sask., with Dr. J. T. Stockings in attendance, salaries as per SRNA with increments and benefits. 40-hr. wk., fully modern nurses' residence, daily bus service to the city. Apply to: Mrs. A. Haug, Matron, Mossbank, Saskatchewan. 10-88-1

Registered Nurses (5 immediately) for Notre Dame Hospital. Apply to: Director of Nursing, Notre Dame Hospital, North Battleford, Saskatchewan. 10-94-1

HOSPITAL FOR SICK CHILDREN

school of nursing

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for

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Candidates with a Bachelor Degree will receive preference

Salaries are according to education and experience

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Four weeks paid vacation

Applications are to be sent to:

THE ASSOCIATE DIRECTOR OF NURSING EDUCATION,

HOSPITAL FOR SICK CHILDREN,

TORONTO 2, ONTARIO.

Registered Nurses (2) one to act as Matron and one for General Duty in 12-bed hospital in south western Saskatchewan. Experience not required for position of Matron. Starting salaries: Registered Nurses for General Duty $310; Matron $345. Comfortable residence near hospital. For further particulars please write or phone: Secretary-Treasurer, Municipal Hospital, Frontier, Saskatchewan. 10-37-1

Registered Male Nurse (Immediately) for 500-bed General Hospital. Opportunity for advancement to supervisory position. Salary commensurate with experience. Must be eligible for Saskatchewan registration. Apply: Director of Nursing Service, Grey Nuns' Hospital, Regina, Saskatchewan. 10-109-7

Registered Nurses for 500-bed modern General Hospital. General Duty positions available on general medical and surgical wards, pediatrics and maternity. Personnel policies comparable to Saskatchewan Registered Nurses' Association recommendations. Recognition given for experience. Must be eligible for Saskatchewan registration. For further information write: Director of Nursing Service, Regina Grey Nuns' Hospital, Regina, Saskatchewan. 10-109-7

Registered Nurses for 36-bed hospital located 85-mi. southwest of Saskatoon. Salary $300 - $360/m, 40-hr. wk., accommodation and board $1.45/day. A new hospital and nurses' residence under construction. Apply stating qualifications to: Miss E. Sparks, Director of Nursing, Union Hospital, Rosetown, Saskatchewan. 10-111-1

Registered Nurses (2) for Vanguard Union Hospital, 19-bed. Starting salary $300 with increments for experience. Pension plan, personnel policies according to Sask. Reg. Nurses' Assoc. recommendations. Residence on grounds. Apply to: Sec.-Treas., Vanguard, Saskatchewan. 10-129-1

Registered Nurses for 10-bed hospital, at Willow Bunch in south central Saskatchewan. Town pop. 700, bus service, recreational facilities etc., 40-hr. wk., wages for Matron $360/m, General Duty Nurses $330 plus board and room in the hospital. Applications to be submitted to: Sec.-Treas., Union Hospital, Willow Bunch, Saskatchewan. 10-138-1

Registered or Graduate General Duty Nurses for 25-bed hospital. Salary as per SRNA policy: $300, room and board: $1.15 per day. 5 day, 40-hr. wk. No split shifts. Evening and night shift with extra pay if out of ordinary rotation. 9 statutory holidays, 3 wk. vacation. Free laundry, modern nurses' residence near hospital with TV — 2 channels. Phone: 2-2668 days, 2-2551 evenings or write: Mrs. Janie Sutherland, Superintendent of Nurses, Union Hospital, Eston, Saskatchewan. 10-33-1

General Duty Nurses (2) for 14-bed hospital, salary and personnel policies in accordance with SRNA recommendations (1963). Apply to: Matron, Union Hospital, Lucky Lake, Saskatchewan. 10-74-1

U.S.A.

Staff and Head Nurses for 100-bed hospital located in the pleasant San Joaquin Valley. Starting salary $395 for Staff Nurses; $415 for Head Nurses; $10 differential for evening and nights. Liberal fringe benefits, modern nurses' residence on grounds at $10/m. Call collect or write: Director of Nursing, County Hospital, Tulare, California. 15-5-44

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits and opportunities for advancement. Top salaries. Apply: Personnel Director, Peininsula Hospital, 1783 El Camino Real, Burlingame, California. 15-5-20

Registered Nurses. Career satisfaction, interest and professional growth unlimited in modern, JCAH accredited 254-bed hospital. Located in one of California's finest areas, recreational, educational and cultural advantages are yours as well as wonderful year-round climate. If this combintion is what you're looking for, contact us now! Staff Nurse entrance salary $370 with automatic increases to $435 per mo., supervisory positions at increased rate. Special area and liberal shift differentials paid. Excellent benefits including Blue Cross hospitalization and surgical coverage and liberal personnel policies. Professional staff appointments available in all clinical areas to those eligible for California licensure. Write today: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California. 15-5-12

Registered Nurses immediate openings in modern 300-bed hospital building. Starting salary $365/m., 5-day 40-hr. wk., liberal vacation and fringe benefits, paid insurances cafeteria. Contact: Mrs. Dorothea Stuart, Personnel Director, Fresno Community Hospital, Fresno 15, California. 15-5-17

Registered Nurses, Staff Nurses for permanent positions, various departments, days, eves., nights. Excellent starting salary, increments, benefits and working conditions in one of the largest and finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California. 15-5-3G

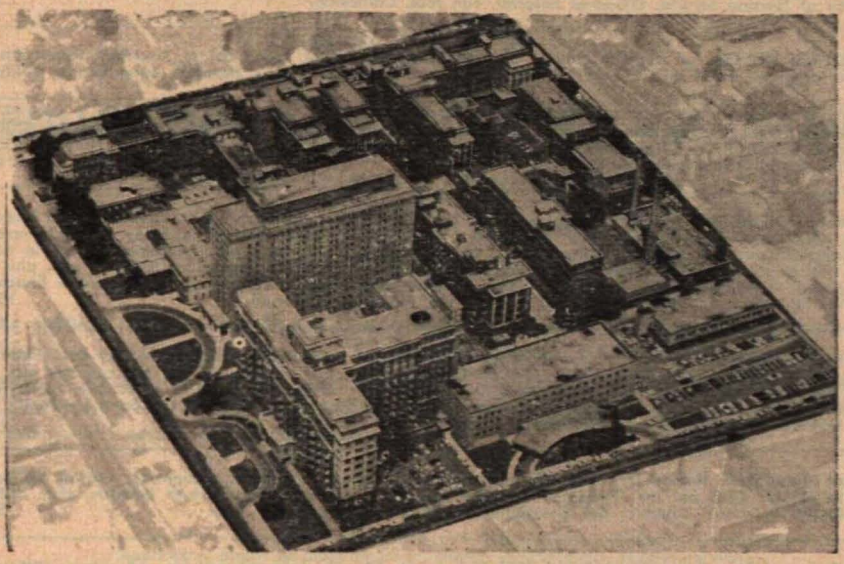
Registered Nurses for modern 125-bed General Hospital in friendly, scenic California town. Starting salary for Staff Nurses $375, liberal shift and specialties differential, 40-hr.wk., no shift rotation, excellent fringe benefits. New Pediatric Unit. Apply: Personnel Department, Mercy Hospital, Redding, California. 15-5-27

Registered Nurses excellent employment opportunities in one of the largest, most modern, and well-equipped voluntary (non-profit) hospitals in California. Its location, in beautiful Sacramento, offers unlimited entertainment and recreational facilities, and is the hub of all summer and winter sports activities. Starting salaries: General Duty $410/m. days, $435/m. P.M.'s and nights. $10/m. differential for psychiatry, Operating Room $435/m. days, $460/m. P.M.'s and nights. Liberal fringe benefits including paid vacations, sick leave and holidays, free hospitalization insurance, employee discounts. Social Security, plus a retirement plan which includes free life insurance. Write: Personnel Department, Sutter Community Hospitals, 2820 "L" Street, Sacramento 16, California. 15-5-43

Registered Nurses for private 258-bed hospital for men, women and children. Staff Nurse salaries from $355-$435, differentials for evenings, nights, communicable disease, operating room and delivery. Opportunities in all clinical areas. Holidays, vacations, sick leaves and health insurance. California registration required. Applications and details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California. 15-5-4

Registered Nurses for 233-bed modern hospital. Positions available — all services, no shift rotation. Liberal benefits, advancement opportunities, educational opportunities in area. Apply: Director of Nursing Service, Kaiser Foundation Hospitals, San Francisco 15, California. 15-5-7

TORONTO GENERAL HOSPITAL



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Registered Nurses and Certified Nursing Assistants for new, modern hospital owned and operated by the Daughters of Charity, located in the heart of Santa Clara Valley, 1 hr. from San Francisco, close to beaches and mountains. Needed immediately, Nurses for all tours of duty in all services, particularly O.B. and O.R. Excellent geographical location, climate, working environment contribute to your job satisfaction. Apply: Director of Nursing Service, O'Connor hospital, San Jose, California. 15-5-10

REGISTERED NURSES for General Duty in 350-bed General Hospital. Good salary, excellent increments and benefit program, ideal climate. **APPLY: Personnel Department, St. Mary's Hospital, Long Beach, California.**

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Starting salary $375 per mo. plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California. 15-5-39

Attention! General Duty Nurses 300-bed fully accredited County Hospital located 2-hr. drive from San Francisco, ocean beaches, & mountain resorts in modern & progressive city of 35,000. 40-hr. 5-day wk., pd. vacation, pd. holidays, pd. sick leave, retirement plan, social security & insurance plan. Accommodations in nurses' home, meals at reasonable rates, uniforms laundered without charge. Starting salary $395 per mo., plus shift & service differentials. Merit increase to $458/m. Must be eligible for California registration. Write: Director of Nursing, Stanislaus County Hospital, 830 Scenic Drive, Modesto, California. 15-5-42

General Duty Staff Nurses for 450-bed fully approved hospital. Salary range per month: Day duty $438-$458, P.M. and night duty $448-$468, 40-hr. wk., paid vacation, 7 pd. holidays per yr., accumulative sick time based on length of service, liberal hospitalization plan, nurses' residence, rooms at reasonable rates. Registration or Permit to work in California required. Address applications to: Chief Nurse, Southern Pacific Railroad Hospital, San Francisco 17, California. 15-5-5B

General Duty Staff Nurses for large General Hospital, located in college community, central California. Starting salary: $413 per mo. Excellent in-service education program, liberal fringe benefits, shift differential. Apply: Personnel Director, 530 Courthouse, Stockton, California. 15-5-36

Staff Duty positions (Nurses) in private 428-bed hospital. Liberal personnel policies and salary. Differential for evening and night duty. Write: Personnel Director, Hospital of The Good Samaritan, 1212 Shatto Street, Los Angeles 17, California. 15-5-3B

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon and night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California. 15-5-3C

Nurses for new 75-bed General Hospital. Resort area. Ideal climate. On beautiful Pacific ocean. Apply to: Director of Nurses, South Coast Community Hospital, South Laguna, California. 15-5-50

Professional Nurses for immediate openings in 274-bed General Hospital, liberal fringe benefits. Enjoy interesting, challenging position in the ideal climate of Santa Monica Bay. Apply: Director of Nursing, Santa Monica Hospital, 1250-16th Street, Santa Monica, California. 15-5-40

Registered Nurses for 74-bed air-conditioned hospital, growing community. Starting salary: $330 per mo., fringe benefits, vacation, sick leave, holidays, life insurance, hospital insurance, 1 meal furnished. Write: Hendry General Hospital, Clewiston, Florida. 15-10-1

General Duty Nurses for 54-bed hospital, minimum starting salary $350 per mo., located near Miami and West Palm Beach. Apply: Director of Nurses, Belle Glade Memorial Hospital, Belle Glade, Florida. 15-10-3

Graduate Nurses (Professional) Choose a career at Chicago's renowned medical-teaching center. Various staff & special assignments available to provide a work setting compatible with your interests & experience, salary to $430/m, plus $50 evening differential, $40 nights and premiums for special assignments. Fringe benefits include vacation to 4-wk. per year, 8 paid holidays, cumulative sick leave, Blue Cross & pension plan, private rooms in modern residence building. Your inquiries are invited: Director, Nursing Service, Dept. C.J.N., Mount Sinai Hospital, 2750 W. 15th Place, Chicago 8, Illinois. 15-14-1C

Staff Nurses (All Areas) Orientation and staff development programs, "nurse-saving" equipment, challenging working environment, individualized living accommodations in new air-conditioned cottages. Opportunity to participate in nursing practice of the finest quality in our 200-bed General Hospital, located along Lake Michigan shoreline, 30 mi. from Chicago. Starting salaries $390-$410 plus $30 differential for 3-11 and 11-7. Write: Director of Nursing, Highland Park Hospital, Highland Park, Illinois, for detailed brochure. 15-14-3

Staff Nurses and Licensed Practical Nurses (Openings in several areas, all shifts). Minimum starting pay $77 R.N.'s; L.P.N.'s $61 per wk., experience considered, differentials paid for reliefs, nights. Every other weekend off in small community hospital 2 miles from Boston. Living quarters available. Contact: Miss Elizabeth B. Kennedy, R.N., Director of Nursing, Chelsea Memorial Hospital, Chelsea, Mass. 15-22-1

Unusual Career Potential for qualified Graduate Staff Nurses. Rochester Methodist Hospital now offers positions in wide variety of medical-surgical services including many specialties. Work with Mayo Clinic staff in our 500-bed fully accredited hospital and be a part of the new and unusual type $14,000,000 hospital to be constructed soon. Good salary schedule. Extensive employee benefits. You would enjoy living in Rochester with its many social and cultural activities. It is also a world renowned medical center. Write for **Free Folders.** Mr. Gene Campbell, Director of Personnel, Rochester Methodist Hospital, Rochester, Minnesota. 15-24-5

NOTICE

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MANITOBA ASSOCIATION OF REGISTERED NURSES

invites applications for the position of

EDUCATIONAL SECRETARY

An applicant must be a registered nurse possessing a baccalaureate degree and experience in nursing education, nursing service, or both. Duties include the organization and management of educational programs developed by the Nursing Education and Nursing Service Committees, and the secretarial work of other boards and committees responsible for the educational functions of the Association.

Application should be made by letter, stating qualifications, experience and salary expected, and should be adressed to:

MISS A. I. MALONEY, President

Manitoba Association of Registered Nurses — 247 Balmoral Street — Winnipeg 1, Manitoba

HEAD NURSE

and

ASSISTANT HEAD NURSE

for

OPERATING ROOM

In a 300-bed modern, fully accredited (JCAH) General Hospital. Expansion program to be completed in July 1963.

Sarnia is a progressive industrial city and is a resort area located at the junction of the St. Clair River and Lake Huron.

Qualifications required:

Experienced postgraduate with administrative ability.

Benefits include:

Excellent personnel policies. Good starting salary with annual increments to maximum. Pension Plan. Group Life, Hospital and Medical Insurance Plans.

Apply to:

PERSONNEL DIRECTOR,
Sarnia General Hospital, Sarnia, Ontario.

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Positions available for qualified Public Health Nurses in various centres in British Columbia. SALARY: $375 - $462 per month; car provided. An opportunity for interesting and challenging professional service in this beautiful and fast-developing Province. For further information and application forms, apply to The Director, Public Health Nursing, Department of Health Services and Hospital Insurance, Parliament Buildings, Victoria, B.C., or to The Chairman, B.C. Civil Service Commission, 544 Michigan Street, Victoria, B.C.

COMPETITION No. 63:101

POSITIONS OPEN — REGISTERED NURSES

Starting Salary $330 per month - Allowance for experience - Enquiries invited - Personnel Policies on request - 40 Hour Week - 9 statutory Holidays - Room and Board - Nurses' Residence $45 per month New Hospital to be completed very soon

Apply to: Mrs. G. AUGER

DIRECTOR OF NURSING, LITTLE LONG LAC HOSPITAL, GERALDTON, ONTARIO

GREY COUNTRY HEALTH UNIT

Will commence operation July 1st, 1963. Applications and enquiries regarding the position of Public Health Staff Nurses are invited. Please apply to the undersigned giving qualifications, experience, salary expected and date available.

H. J. HENDERSON

COUNTY CLERK-TREASURER, COUNTY COURT HOUSE, OWEN SOUND, ONTARIO.

Rehabilitation Nursing — Nurses needed in Rehabilitation Center for Children and Adults located in scenic mountain and lake region, 75-mi. from Boston, 240-mi. from N.Y.C. **Director of Nursing** — degree and previous administrative experience at least on supervisory level required. Some rehabilitation background desirable. Salary commensurate with education and experience. **Staff Nurses** — previous experience in pediatrics, orthopedics, or rehabilitation desirable. Opportunity for advancement. Beginning salary $4,140-$4,500, depending on background and experience. Apply: Mary Ruth Pippen, Director, Crotched Mountain Rehabilitation Center, Greenfield, New Hampshire. 15-30-1

Staff Nurses 380-bed hosp. new 120 med-surg. unit. Trans. pd. 1st class air to Albuq. and return within U.S. in exchange for 1-yr. emp. contract. Come to New Mexico "Land of Enchantment." Career opportunities, largest pvt. JCAH accredited hosp. in state; near U. of New Mexico, R.N. & B.S. pgm. Practical Nurse pgm. accredited state & NAPNE. Vacancies, Med-Surg. & occasionally O.B., Peds., & O.R., salaries $315 per mo. even., night or O.R. with call; 6-mo. increases up to $375; days $300 per mo. with increases up to $360. Rotation from day duty is required only when no person desiring permanent P.M. of night tour is available. Liberal personnel policies include: optional Blue Cross, Discount Hosp. Services, pd. sick leave cumulative to 5 wks., annual physical exam., vacation 1 yr. — 2 wks., 2 yrs. — 3 wks., 5 yrs. — 4 wks. Active in-service pgm. Occasional vacancy hosp. owned apts. New Mexico licensure as professional nurse & U.S. Citizenship (or Immigration Visa) required. Write or call collect: Mrs. Emily J. Tuttle, Dir. of Nursing, Presbyterian Hospital Center, 1012 Gold, S.E., Albuquerque, New Mexico. Phone 243-5611. 15-32-3

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric and pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th Street, Cleveland 6, Ohio. 15-36-1D

Staff Nurses for modern 400-bed tuberculosis hospital, suburban Cleveland, Ohio. Monthly salaries start at $396 with semi-annual increments. Extra for night and relief duty, 5-day work wk., 3-wk. paid vacation, 6 paid holidays, liberal sick leave, comfortable accommodations in nurses' residence at low rate. Learn and earn at a progressive accredited hospital in a growing community. Write: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio. 15-36-1E

Registered Nurse (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary starts at $372. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon. 15-38-1

Staff Nurses (All Clinical Services) Base salary $350, opportunities for advancement, differential for 3-11 & 11-7 shifts, personnel policies, sick leave, retirement plan, 3-wk. vacation & laundry of uniforms. Orientation & in-service programs, housing available on campus. Apply: Director of Nursing Service, University of Texas Medical Branch Hospitals, Galveston, Texas. 15-44-5

General Duty Nurses for 232-bed General Hospital; university city; needs 3-11 and 11-7 shift nurses, salary $380-$420 and $375-$415/m respectively, excellent benefits, including medical and life insurance. Extensive intern-resident educational program. Free quarters available the first month. Must have psychiatric training to obtain a Washington nursing licence. Write Personnel Manager, Virginia Mason Hospital, 1111 Terry Avenue, Seattle 1, Washington. "Work in Seattle and enjoy moderate winters and comfortable summers." 15-48-2B

Staff Nurses The University Hospital wants you if you are seeking challenging work. Modern 320-bed teaching and research hospital located on the University of Washington campus. In-patient services include Clinical Research, Premature Centre, Hemodialysis, Physical Medicine and Rehabilitation, Child Psychiatry and Adult Psychiatry in addition to those of a general hospital. Salary $360-$422, evening and night differential, liberal employee benefits including tuition free courses after 6 months. Apply: University Hospital, Seattle 5, Washington. 15-48-2D

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and

CERTIFIED NURSING ASSISTANTS

for

360-bed accredited General Hospital. Registered Nurses salary range $315-$355 per month with consideration for contemporary experience or special preparation.

Certified Nursing Assistants $210 - $240 per month.

For further information write:

Director of Nursing Service
METROPOLITAN GENERAL HOSPITAL
Windsor, Ontario.

NURSING OFFICE SUPERVISOR

Required for 321-bed Medical and Rehabilitation Unit with expansion program. University preparation in administration of Nursing Service and experience essential.

Monthly salary with diploma $407.30 to $476.60

Monthly salary with degree $416 to $485.30

Good personnel policies.

Position available for late summer.

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SUPERINTENDENT OF NURSES,
Division "H",
Henderson General Hospital,
Hamilton, Ontario.

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LONDON, ONTARIO

Modern 900-bed hospital

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Registered Nurses for all services

and

Certified Nursing Assistants

40 hour week - Pension plan - Good salaries and Personnel Policies.

Apply :

DIRECTOR OF NURSING
VICTORIA HOSPITAL, LONDON, ONT.

ST. JOSEPH'S HOSPITAL

Toronto, Ontario

REGISTERED NURSES

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600-bed fully accredited hospital provides experience in Oeparting Room, Recovery Room, Intensive Care Unit, Pediatrics, Orthopedics, Obstetrics, General Surgery and Medicine.

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Salary is commensurate with preparation and experience.

Benefits include Pension Plan, Group Life Insurance, sick leave — 12 days after one year, Ontario Hospital Insurance — 50% payment by hospital.

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for all departments

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DIRECTOR OF NURSING

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Duties include classroom and clinical instruction in certain areas of an integrated course in Medical-Surgical Nursing.

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200 Church Street, Weston, Ontario - Telephone 249-8111 (Toronto)

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Gross salary $325 monthly with annual increments for 4 years to $365.

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METROPOLITAN GENERAL HOSPITAL

requires

INSTRUCTOR IN PEDIATRIC NURSING.

This is an opportunity to participate in the development of a progressive program which emphasizes educational nursing experiences for the student. The program consists of 2 basic, preparatory years followed by one year of Nursing Internship. One class of 32 students is admitted annually. **Duties include:** Clinical and Classroom Instruction in an integrated program of Maternal and Child Care. **Requirements:** University preparation in Nursing Education. — Salary differential for Degree. — Duties to commence August, 1963.

For further information, contact:

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MEDICAL NURSING INSTRUCTOR (MALE SERVICE)
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Required

For School of Nursing with maximum enrollment of 90 students.

Graduate Staff Nurses for Medical, Surgical, Pediatric and Obstetrical Service.

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A modern, progressive, 850-bed hospital located in the centre of Ontario's Golden Horseshoe, has openings for :

1) Head Nurses for Medical or Surgical units. Postgraduate study preferred
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For further information write to :

THE DIRECTOR OF NURSING SERVICE
St. Joseph's Hospital, Hamilton, Ontario.

UNIVERSITY HOSPITAL

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Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week.

Salary range $300 to $360 gross per month. Differential for evening and night duty. Temporary residence accommodation if desired.

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required immediately:

CLINICAL AND CLASSROOM INSTRUCTORS

465-bed, modern air-conditioned hospital. Classroom in all clinical areas. Salary based on qualifications, experience.

GENERAL DUTY NURSES AND NURSING ASSISTANTS

FOR ALL DEPT.'S PERSONNEL POLICIES FURNISHED ON REQUEST.

Apply: Director of Nursing, St. Mary's General Hospital, Kitchener, Ont.

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HEAD NURSES AND GENERAL DUTY STAFF NURSES

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All departments of a new 450-bed General Hospital situated just 7 miles west of Metropolitan Toronto.

Salaries paid in accordance with the Toronto Schedule.

Many fringe benefits, including portable pensions.

Additional salary allowances for postgraduate qualifications.

For information or application, write to:

DIRECTOR OF NURSING,

South Peel Hospital, Cooksville, Ontario.

GRADUATE STAFF NURSES

Opportunities for men and women on all services including metabolism, rehabilitation, psychiatry, recovery room, medicine, surgery, pediatrics, obstetrics, operating room, and emergency room. Well planned orientation and in-service programs, tuition-free courses at Western Reserve University after 3 months employment, low cost housing in nurses' residence. Liberal personnel policies with premium for evening and night tours of duty. Starting rate based on experience and enducation. Staff nurse salary range $385 to $425. Write for more information and the booklet "New Horizons in Nursing," to:

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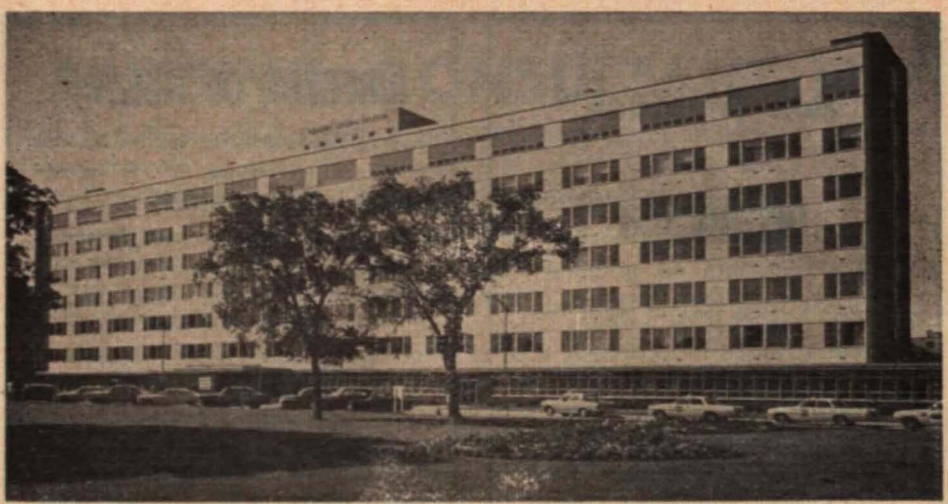

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